


CA28NPM 86
-70H27

Government
Publications

Ontario [Commissions and
committees of inquiry] Committee
on the healing arts.

Study
[no. 10] Nursing in Ontario
1970



Digitized by the Internet Archive
in 2024 with funding from
University of Toronto

<https://archive.org/details/39020914050169>

I
64

NURSING IN ONTARIO

V. V. MURRAY

A STUDY FOR
THE COMMITTEE ON THE NURSING ACT
1971





NURSING IN ONTARIO

V. V. MURRAY

**A STUDY FOR
THE COMMITTEE ON THE HEALING ARTS
1970**

Printed and published by
the Queen's Printer
Toronto 1970

FOREWORD

The Committee on the Healing Arts was established by the Province of Ontario, Order in Council 3038/66, dated July 14, 1966.

In February 1967, the Committee commissioned Professor V. V. Murray of the Faculty of Administrative Studies and Department of Sociology, York University, to undertake a study of Nursing in Ontario. The following is a study prepared by Professor Murray and submitted to the Committee in March 1968.

The statements and opinions contained in this study are those of Professor Murray, and publication of this study does not necessarily mean that all the statements and opinions are endorsed by the Committee.

I. R. Dowie, Chairman

Horace Krever

M. C. Urquhart

PREFACE

This report was prepared for the Committee on the Healing Arts during the winter of 1967-1968. The information on which it is based was gathered throughout the spring, summer and fall of 1967. Between the time the report was submitted in March 1968 and the present there have, of course, been some changes in the situations studied and numerous updated statistics have been published.

Though I have not spent a major part of my time keeping up with developments in nursing over the past ten months, I have tried to remain aware of any major changes in the major issues and problem areas which our study focused upon. As far as I could tell, conditions either remain basically the same now as before, or are changing in accord with trends established when the study was done. For example, there has been no major move towards more efficient and effective utilization of nursing resources; the predicted localized increases in demand for nurses in areas where major hospital expansions have been undertaken are coming about, causing temporary local shortages; also, as described in the report, the rate of increase in the nursing supply is slowly rising as more effort is devoted to luring back "retired" nurses and as more schools complete curriculum and structural changes allowing them to concentrate on expanding their enrolments. *Major* increases in the number of new graduates is still inhibited, however, by the genuine teachers' shortage. Basic wages for nurses have continued to rise, but this year, for the first time, wages in Ontario were surpassed by those in other provinces. Inequities in hours, working conditions, and pay differentials remain unchanged. Organization of registered nurses for collective bargaining continues to grow steadily, though not spectacularly—particularly among hospitals (since January 1967, the number of hospitals organized has increased from two to fifteen with six more currently in the process of organizing).

In the realm of nursing education, there appear to be no significant changes in the basic problems of excessive diversity of approaches to diploma education and the painful slowness in increasing the number of university trained nurses. Finally, the weaknesses in the many and complex decision-making structures which have lain behind all the major substantive problems facing the profession have not, to my knowledge, undergone any significant changes since the report was written.

Hopefully, therefore, in spite of the time lag between its writing and publication, this report remains relevant and useful as a source of ideas for the future improvement of nursing care in Ontario.

V. V. M.

ACKNOWLEDGEMENTS

The author would like to express his sincere appreciation to Mrs. Kathryn Arnold, Mrs. Viola Edwards and Mrs. Jean Joyner for their invaluable assistance and unflagging enthusiasm in the preparation of this study. Though the fact that we are all amateurs in the field of nursing will perhaps be all too obvious to the experts who read this report, whatever is valuable in it, plus the fact that it was completed to meet the Committee's deadline in little more than ten months, is largely due to their efforts.

We would like to convey our gratitude to the many individuals in the nursing profession and those associated with it, who gave so unstintingly of their time when we visited them. We literally could not have done the job without the full and frank cooperation obtained from members of the Ontario College of Nurses, the Ontario Hospital Services Commission, the Department of Health, the Registered Nurses' Association of Ontario, the Canadian Nurses' Association, the Ontario Hospital Association, the Ontario Medical Association and, most importantly, the many officials of the individual hospitals, nursing schools and faculties which we visited.

CONTENTS

Foreword	<i>v</i>
Preface	<i>vii</i>
Acknowledgements	<i>ix</i>

Chapter 1: Introduction	1
-------------------------------	---

Part One: Issues of Nursing Practice

Chapter 2: The Practice of Nursing	8
Chapter 3: Conditions of Work in Nursing	54
Chapter 4: Supply and Demand in Nursing	77
Chapter 5: Qualifications for Nursing Practice	121

Part Two: Nursing Education

Introduction	130
Chapter 6: The Quality of Education for Registered Nurses: Curriculum, Pedagogy and Standards	131
Chapter 7: The Quantity of Education for the Registered Nurse	152
Chapter 8: Education for the R.N.A. and Other Nursing Classifications	165
Chapter 9: In-Service Training in Nursing	172
Chapter 10: The Structure and Process of Decision-Making in Nursing Education	175
Chapter 11: Summary and Conclusions: Alternative Approaches to Problems in Nursing	198

Appendices

Appendix I	Coding System for Nursing Activity Studies Conducted by the OHSC	243
Appendix II	Studies of Overall Nursing Supply and Demand in Hospitals (in 1964, 1965 and 1966), Prepared by the OHSC	252
Appendix III	Study of Nursing Supply and Demand, Prepared for the Nursing Education Advisory Committee, to the Minister of Health	278

Tables

Table 1	Numbers of Nursing Personnel Studied by Position Title and Nursing Unit, OHSC Activity Studies, 1960-1967	16
Table 2	Percentage of Time Spent in Activities "Above" or "Below" Level of Work	17
Table 3	Percentage of Time Spent in Specific "Non-nursing Activities" by Main Classes of Nursing Personnel	18
Table 4	Average Starting Salaries and Annual Salary Increase Per Cent for Major Nursing Categories, Ontario, 1964-1968	55
Table 5	Differentials Paid for Seniority or "Merit" in Nineteen Ontario Hospitals, 1967	59
Table 6	Monthly Salary Ranges and Differentials for Head Nurses and Nursing School Instructors in Nineteen Ontario Hospitals, 1967	60
Table 7	Variation in Monthly Nursing Salaries by Locality With Ontario, 1968	62
Table 8	Differences in Average Monthly Starting Salaries for Nursing Personnel Between Ontario and Major United States Regions, 1966 (Non-federal Hospitals)	63
Table 9	Nursing Hours of Care per Day and Distribution of Care Between Nursing Department Personnel in Ontario Hospitals, 1964-1966	83
Table 10	Full-time Equivalent Staff by Classification for Years 1964 to 1966 and Projected for Years 1967 and 1968	85
Table 11	Registered Nurses in Canada by Status of Employment, 1965-1966	91
Table 12	Registered Nurses and Registered Nursing Assistants, Ontario, 1963-1967	91
Table 13	Registered Nurses by Status of Employment, Ontario, 1965-1966	92

Table 14	Number of Orderlies and Other Nursing Personnel Employed in Ontario Hospitals, 1964, 1965	93
Table 15	Proportions of Total Employed Registered Nurses and Registered Nursing Assistants in Various Fields of Employment, Ontario, 1965-1966	95
Table 16	Numbers of R.N.'s and R.N.A.'s Classified by Field of Employment, Ontario, 1965-1966	96
Table 17	Registered Nurses Employed in Nursing Classified by Type of Position Held, Ontario, 1965-1966	97
Table 18	Highest Level of Educational Preparations, Employed R.N.'s, Ontario, 1965-1966	98
Table 19	Proportions of All R.N.'s Employed in Nursing, Classified by Field of Employment and Highest Level of Educational Preparation, Ontario, 1965-1966	99
Table 20	Proportions of All R.N.'s Employed in Nursing, Classified by Type of Position Held and Highest Level of Educational Preparation, Ontario, 1965-1966	100
Table 21	Mean Turnover Rate of Full-time Graduate Nurses — General Duty, by Type of Hospital and Province, Canada, 1965	102
Table 22	Mean Turnover Rate of Full-time Qualified Assistants, by Type of Hospital and Province, Canada, 1965	103
Table 23	Mean Turnover Rate of Orderlies, by Type of Hospital and Province, Canada, 1965	103
Table 24	Nursing Department Staff Turnover Rates, 1966	106
Table 25	Nursing Department Staff Turnover Rates, 1966	107
Table 26	Summary of the Decision Structure Affecting the Supply of Nursing Resources	114
Table 27	Minimum Academic Requirements for Admission to Diploma Schools of Nursing in Ontario, 1967	140
Table 28	Enrolments and Graduations, Nursing Schools Preparing Registered Nurses, Ontario, 1965-1967	152
Table 29	Actual and Estimated Capacity of Ontario Diploma Nursing Schools, 1967-1971	153
Table 30	Graduates from Nursing Assistant Training Centres Registered by the College of Nurses, Ontario, 1963-1966	168

Table A1	Comparison of Nursing Department Hours of Work for the Years 1964 and 1965	256
Table A2	Comparison of Nursing Department Hours of Care per Diem and Distribution of Graduate Nurse Hours of Work, 1964 and 1965	258
Table A3	Comparison of Full-time Equivalent Nursing Department Personnel by Classification for the Years 1964 and 1965	260
Table A4	Comparison of Full-time Equivalent Nursing Department Personnel by Classification for the Years 1964 and 1965	262
Table A5	Full-time Equivalent Staff by Classification for Years 1963 to 1965 and Projected for Years 1966 and 1967	264
Table A6	Comparison of Nursing Department Hours of Work for the Years 1965 and 1966	268
Table A7	Comparison of Nursing Department Hours of Care Per Diem and Distribution of Graduate Nurse Hours of Work, 1965 and 1966	270
Table A8	Comparison of Full-time Equivalent Nursing Department Personnel by Classification for the Years 1965 and 1966	272
Table A9	Comparison of Full-time Equivalent Nursing Department Personnel by Classification for the years 1965 and 1966	274
Table A10	Full-time Equivalent Staff by Classification for years 1964 to 1966 and Projected for Years 1967 and 1968	276

Chapter 1 Introduction

The Nature of the Study

This study of the nursing profession in Ontario has had several objectives. From the point of view of the Committee on the Healing Arts, it was hoped it would provide a comprehensive review of existing information and opinion on the critical issues of the supply of and demand for nurses, the control of the profession, and the education of nurses. From the point of view of the nursing profession there is the possibility that the work of dispassionate observers from outside the profession might provide some new insights into the nature of problems facing the profession, their causes, and their remedies. From the point of view of the author, a university-based social scientist with a general interest in the determinants of behaviour in the world of work, the study provided a unique opportunity to make a contribution to a relatively new area of interest in organization theory, that of the decision-making process. In particular, the nursing profession in Ontario offers a rare chance to study this process when several organizations, some state-controlled and others not, possess partial authority over the issues requiring decision.

To those familiar with the nursing profession, the very idea of yet another study of nursing may seem most superfluous and indeed, relative to other major occupations in the world, it does appear that nursing is one of the most frequently written about.

There is an immense amount of polemical and theoretical writing plus a fair number of empirical reports on the historical evolution of nursing; the role of the nurse in hospitals vis-à-vis the patient, the doctor, administrators and other nurses; the role of the nurse in the community; the effects of various types and systems of nursing education on the nurse's values, knowledge and work behaviour; the relationship between nursing and changing social values regarding health, medicine and the role of women in society; the determinants of choice of nursing as a career, and mobility into and out of practice; the causes and effects of economic and legal conditions prevailing in nursing, and so on.¹

In spite of all this interest on the part of nursing leaders and teachers as well as scholars from all the social sciences, apparently little effort has been devoted explicitly to trying to understand how the key decisions have been ar-

¹See Leo W. Simmons and Virginia Henderson, *Nursing Research: A Survey and Assessment*, Appleton-Century, Crofts, New York, 1964, for what seems to be a comprehensive review of these studies up to the early 1960's.

2 Introduction

rived at regarding what a nurse should do, what qualifications she should possess, how she should be educated, and so on. Instead, it has been the practice to take the decision to do things in a certain way as given, and then to ask what the effects of such policies or practices are on such matters as the quality of care or the supply of nurses. The answers arrived at have sometimes resulted in decisions to change the given situation, but not always. Thus, although certain nursing leaders have advocated since the late nineteenth century that nursing education be removed from control of hospitals, there has been a significant move in this direction only since the end of World War II; and, at that, progress is still slow, especially in Canada. While there has been some research and much writing on the advantages and disadvantages of having education controlled by hospitals or independent sources, little study has been made of who does in fact have the say about the control of nursing schools and what factors affect their decisions. The same comment holds true for almost all other issues in nursing practice and education.

Of course, it is not possible to analyze *only* the decision-making process in nursing. No conclusions regarding how to change this process (if it is to be changed at all) can be reached without a summary and analysis of existing fact and opinion on each issue under consideration.

The issues of nursing practice and education identified in this report will be discussed from three perspectives.

- 1) *Current-future conditions.* Here we will present a resumé of existing facts and figures on the issue and our expectations of future conditions, compared, if relevant, with conditions in other Canadian provinces or in other countries. This section will also identify problems in gathering the facts or measuring the severity of conditions.
- 2) *Review of informed opinion.* A resumé is given of the main points of view held by informed persons or groups with an interest in knowing what is wrong with the current situation and how things *should* be.
- 3) *Decision structure and process.* Here we will try, first, to identify the locus of decision-making for each issue and the process by which decisions are arrived at—that is, the steps involved in movement from the point of recognition that a decision is necessary to the point at which final plans, policies or practices are laid down; and second, to analyze factors which influence the direction of decisions.

The basic steps in the making of any decision are recognition of the problem or the setting of desired objectives or goals; search for alternative means for solving the problem or attaining the goals; evaluation of the alternatives discovered

in terms of their perceived costs, benefits and feasibility for implementation; choice of the best available alternative; implementation; and reassessment of the decision in the light of feedback on the degree of success attained.

At each of these points in the process one or more of the following can affect the outcome: pre-existing attitudes or beliefs on the part of the decision-maker concerning the issue; the adequacy or availability of information on the issue; pressures (constraints) exerted by legal statutes and regulations, or by the availability of time, personnel, money, material and facilities, which affect the search for alternatives or the implementation of particular solutions; pressures brought to bear by individuals or groups to be affected by the decision; unintentional influences exerted by individuals or groups with which the decision-maker identifies either positively or negatively; unrecognized influences of general norms and values prevailing in the society at large.

Issues Investigated in the Study

The issues investigated may be grouped under two main headings: those having to do with the practice of nursing within hospitals and outside them, and those pertaining to educational preparation for nursing. The specific issues are stated here mainly in terms of the most important policy implications they raise.

Issues of Practice

The nature of nursing activity. Who should do what in nursing? Much controversy rages as to what activities constitute the proper work of R.N.'s with university degrees, R.N.'s with diplomas, registered nursing assistants (R.N.A.'s), ward aides and orderlies. The decisions on this question form the basis for the answer to two of the key issues in nursing everywhere — the number of each type of nurse needed and how each type should be educated.

Working conditions in nursing. What are current conditions regarding wages, hours, fringe benefits and other key elements of the job context which serve to attract the various classes of nurse and keep them with a particular employer?

Supply and demand. What is the need for the various classes of nurse now and in the foreseeable future? Are there and will there be enough nurses to meet the need? What are the best means for maintaining a proper balance between demand and supply? Included in this issue is a discussion of the dilemma between quantity and quality in nursing which is reflected in the standards and conditions laid down by law regarding admission to practice.

Issues of Education

Curriculum and duration of education. What should be the content of education for the various classes of nurse and how long should the training go on? Who should control matters of nursing education?

4 Introduction

Pedagogy in nursing education. How should nursing be taught? What is the proper proportion of the total time to be spent on clinical practice? Are there enough of the right kind of clinical facilities?

Teaching staff. What is the proper preparation for teaching nursing? Are there enough teachers?

Recruitment and admission standards. Are enough people choosing to enter nursing training? What should be the standards for admission to the various types of educational programs?

How the Study Was Done

It must be stated quite plainly that the investigators carrying out this study began it with scarcely any expert knowledge of the job of nursing or the nursing profession. Our competence lay solely in possessing specialized knowledge of the sociology of occupations and work organizations, and of the methods for studying these. We had also some acquaintance with the special area of medical sociology, which concentrates on the sociological influences on, and effects of, the means for providing care and treatment of the sick.

The investigating team comprised a research director (the author) and three research assistants, all of whom had training and experience in social science research. As a group we began by reading previous studies and the theoretical writings on nursing by nursing leaders, teachers, hospital administrators, doctors and social scientists. We also studied briefs to, and hearings of, the Committee on the Healing Arts pertaining to nursing and interviewed a number of prominent nurses in the Toronto area for their views. Further factual material was gathered from associations of nurses, hospitals and doctors, and from government sources, both within the province and outside; and by means of two special questionnaires given to a sample of hospitals and nursing schools by the Committee on the Healing Arts and our research group, respectively.

Following this orientation to nursing, we devised a comprehensive outline of the study and prepared detailed interview schedules for use in carrying out a series of field visits to a sample of hospitals, public health agencies and nursing schools.

We visited sixteen hospitals, eighteen training centres for R.N.'s (degree and diploma) and R.N.A.'s, and four public health agencies (private and government). Before, during and after the period that field visits were being made, the researchers interviewed about thirty officials holding positions relating to nursing in the Ontario Hospital Services Commission, the College of Nurses, the Ontario Department of Health, the Registered Nurses' Association of Ontario, the Canadian Nurses' Association, the Ontario Association of Registered Nursing Assistants, the Ontario Hospital Association, and the Ontario Medical Association.

On field visits to hospitals the procedure followed was to talk to the hospital administrator, the director of nursing, the assistant director of nursing service (if applicable), and one to three head nurses. In some but not all hospitals, opportunity was provided to talk to nursing supervisors, directors of in-service training, staff nurses, and medical chiefs-of-staff. In nursing schools we talked to the director of the school or program, to her immediate assistants, and, in some cases, to teachers.

Interviews were relatively unstructured, with the prepared interview schedule used mainly as a reminder of areas to cover rather than as a rigid guide in terms of the wording and sequence of questions. Most questions were of an open-ended variety thus permitting the interviewee to express answers in his or her own way.

The sample of hospitals visited comprised 16 per cent of the total of 229 hospitals in Ontario supported by the Ontario Hospital Services Commission or the federal government. Private hospitals, psychiatric hospitals (the Ontario Hospitals) and nursing homes were not visited. The following is a breakdown of the sample according to various significant characteristics:

The sample by region:² Toronto region, 7; Northern region, 4; Hamilton and London regions, 3; Kingston region, 2.

By size of urban area in which located: cities (over 50,000 population), 10; towns (between 10,000 and 50,000), 3; small towns (under 10,000), 3.

By size of hospital: large (over 500 beds), 5; medium (between 200 and 499), 5; small (under 200 beds), 6.

By type of hospital: general, 14 (includes one federally run hospital for Indians); chronic, 1; convalescent, 1.

By ownership: independently owned and operated, 12; religious order, 3; federal government, 1.

The sample of centres for nursing education programs totalled eighteen, or 15 per cent of the seventy or so programs preparing R.N.'s and fifty programs preparing R.N.A.'s in the province.³ This sample breaks down as follows:

Hospital-based diploma schools of nursing for R.N. (this includes schools based primarily in one hospital or schools which are controlled by the Board of Trustees of one hospital)	8
Independently operated diploma R.N. schools	2
Community college operated diploma schools	1
Regional diploma R.N. schools	3
University degree R.N. schools	2
R.N.A. programs	2

²Regional boundaries are defined in the Ontario Department of Health, *42nd Annual Report*, 1966, p. 13.

³Since the total number of programs is growing monthly, figures on totals of programs are approximate.

Of the fourteen diploma R.N. schools visited, four had established two-year programs; one was commencing a two-year program in 1967; and the rest were either "two plus one" or traditional three-year programs.

It should be mentioned that the sample of hospitals and educational centres visited was not truly representative in terms of proper statistical sampling theory; however, it was chosen in an informal way to be as representative as we could make it within the constraints of time, money and availability of key personnel for interviewing. It should be mentioned also that in virtually every case the institutions and individuals visited were exceedingly cooperative. Consistently there was great willingness to help the investigators.

As a final note regarding the sample of institutions visited, the reader should be reminded that the field visits were intended to provide insight primarily into the decision-making process underlying the various nursing issues investigated. Though the visits yielded much factual material on current and future conditions, most of the material on conditions was obtained from pre-existing sources or from figures gathered by nursing or government organizations. Most of these data refer to province-wide conditions and are based on reports from *all* hospitals or schools, not just those in the sample we visited.

Weaknesses of the Study

In reading the following report on the findings of this study and the analysis of them, the reader should be aware of certain weaknesses in the methodology of the study. While we are confident that this report presents a basically valid depiction and analysis of the situation in nursing in Ontario today, because of these weaknesses we cannot claim that all the conclusions are fully supported and "proven" by sound empirical data.

Regarding the statistics presented, some are more than one year old simply because more recent figures were not yet available; in a few cases (noted later) of statistics from different sources, there are discrepancies because diverse interpretations were used by reporting schools or hospitals of the criteria for classifying or tabulating the figures.

Regarding description and analysis of the decision-making process, our conclusions are necessarily based on subjective evidence yielded by the field interviews. No statistical analyses are possible for such data.

The sample of hospitals and schools visited could be biased, although we are not aware of any such bias other than the deliberate exclusion of private and psychiatric hospitals, and of nursing homes. Psychiatric nursing is covered in a separate study prepared for the Committee. Private hospitals and nursing homes were not visited because they employ a relatively small proportion of R.N.'s and R.N.A.'s (though special problems involving nursing in such institutions are discussed in the report).

The researchers did not have time to observe large numbers of nursing personnel or nursing students actually at work; nor did we have an opportunity to interview many of the rank-and-file members of the occupation. Our comments on the attitudes and behaviour of this group therefore are based mainly on the reports of people above the rank-and-file level. Note, however, that we did study a number of published research reports done by others who had gathered data directly from samples of the rank and file.

As one significant addition and counterbalance to these weaknesses we can assert with some conviction that all members of the research team were entirely objective in their view of the various nursing issues. Since none of us had had any previous exposure to the special problems of this occupational group, we were entirely uncommitted to any particular point of view prior to commencing the study and managed to preserve this detached position, as far as we could tell, throughout the course of our labours.

Part One: Issues of Nursing Practice

Chapter 2 The Practice Of Nursing

Introduction

It is difficult to overemphasize the importance of the questions: What is nursing? and what should the various classes of nurse do? The way one implicitly or explicitly answers these basic questions is probably the most important determinant of one's position on almost all the controversial policy issues in the field of nursing: issues such as whether or not there is a serious shortage of nurses, how the various classes of nurse should be educated, how they should be paid, and what should be the standards for admission to practice.

Take, for example, the question of how many nurses are needed to provide optimum patient care in the province's hospitals. It will be seen in Chapter 4 that there are two criteria for judging the overall adequacy of nurse staffing in the province's hospitals: how close they come to providing an average of 3.5 hours of nursing care per patient per day; and how close they come to maintaining a nursing staff ratio of 60 per cent R.N.'s to 40 per cent nurse's aids. From such calculations of numbers needed, one can arrive at the total provincial need, compare it to the total supply, and arrive at an estimate of nursing shortage or surplus. Clearly, though, these rules of thumb must be based on estimates and assumptions of what the various classes of nurse should be doing with their time. Say, for example, that in calculating the 3.5 nursing hours, it is assumed that an average of 20 per cent of an R.N.'s time will be spent doing various kinds of required paper work. If, in fact, it should prove feasible to reduce this paper work to 5 per cent of her time, obviously the nurse would have more time to spend with the patient. This would mean that fewer R.N.'s would be needed to provide the same patient care; or that fewer non-registered aides would be needed, since R.N.'s could start doing patient care tasks done by these aides; or the same numbers of all types of nursing staff could be retained and more direct bedside care given to the same number of patients, or the same amount to more patients.

In this chapter under the heading "Current Conditions" we will identify the basic positions in nursing and the sites where nurses practise. A basic description of the main activities involved in the practice of nursing will follow, and a more detailed discussion of the specific activities of the various classes of nurse in the most common employing organizations. As well as simply describing activities,

we will attempt to analyze the proportion of time devoted to each main type of activity.

The section, "Opinion on Current Conditions", contains a summary and discussion of the more commonly held attitudes concerning how nursing *should* be practised.

Under the heading, "Decision-Making Structure and Process", is a description of the key positions which involve the responsibility for deciding how nursing will be practised in Ontario. We will also discuss the way these decisions for the organization and administration of nursing care are made. The section will conclude with an analysis of the forces and factors which have the greatest influence on these decisions.

The chapter ends with a summary of the major problems of nursing practice and a review of the factors which create them.

Current Conditions

Who Nurses?

The fact of the matter is that, as professional nursing organizations tirelessly point out, *anyone* may nurse in Ontario in the sense of giving care to sick people in return for money. That some people with scarcely any training or experience do hire themselves out as "nurses" is a matter of record and constitutes a special problem which will be treated separately in this report. For the purposes of this study, however, we concentrated for the most part on the major *recognized* occupational classes practising nursing in Ontario: registered nurses, registered nursing assistants, non-registered nurse's aides and orderlies. The activities which comprise the work of these groups are discussed below.

Who Employs Nurses?

By far the largest employer of all classes of nursing personnel is hospitals (72 per cent of employed R.N.'s). The next largest group of employers are the public and private agencies which provide health services to the general public outside hospitals (11 per cent of R.N.'s). Another small proportion (4 per cent of R.N.'s) act as private duty nurses. Private industry and government employ a few, as do private nursing homes and various private clinics and doctors' offices. (See Chapter 4 "Nursing Supply and Demand" for a detailed numerical breakdown of the utilization of nursing services.)

What Constitutes "Nursing"?

While there has been continuous debate both within and outside the nursing profession as to what nursing *should* be, there is little disagreement over what nurses actually do, at least when these activities are stated in relatively broad terms. Many frameworks for breaking down the nurse's job have been advanced; however, the one we prefer attempts to distinguish between: 1) direct care activities; 2) direct cure activities; and 3) adjunct activities — that is, activities *in support*

of direct care and cure activities. Needless to say, the borderlines of these three categories are sometimes fuzzy, but they nevertheless serve as a useful scheme for describing what is generally involved in nursing today.¹

Direct Care

The original and still uniquely *nursing* activities are those required in giving both physical and psychological care so as to prevent or alleviate discomfort due to illness. Care activities are distinct from cure activities in that they do not directly form part of the specific therapy designed (usually by physicians) to prevent or combat an incipient or actual illness. The point is that although they are not part of the specific therapeutic program, care activities *are* usually a vital condition affecting the effectiveness of therapy. Thus, if the patient is not kept clean, free from infection, properly positioned, and so on, few therapies for any illness of consequence will be optimally effective.

Direct care activities can be broken down between physical care and psychological care ("tender loving care" is the popular phrase which has always denoted the latter aspect of nursing care to the lay public). Furthermore, within each of these two categories one can distinguish between judgemental and evaluative activities on the one hand, and procedures or the actual performance of care actions on, for, or with the patient, on the other. While not presuming to be complete or even technically correct, the following list includes *examples* of care activities of each type.

1) Physical Care Activities

Judgemental and evaluative. This is the evaluation of the patient's ability to perform basic self-care activities, and decisions as to what aspects need to be performed for him; planning the frequency and sequence of care procedures to be performed for the patient; noting and evaluating the nature and degree of discomfort being suffered by the patient due to conditions in his immediate environment; noting and analyzing unsterile conditions which might affect recovery.

Procedures. This includes feeding, bathing, positioning, skin care, bed-making, giving exercise, aiding elimination, keeping the environment quiet and orderly to facilitate rest and sleep.

2) Psychological Care Activities

These activities are of course much *more* than just the "tender loving" components of care. They imply that attention must be paid to the patient's mental and emotional state, his feeling of well-being. It is assumed that movement of the patient from a state of dependence to independence in terms of his physical condition should be paralleled by a similar movement in his psychological state.

¹It is a fascinating, though separate, endeavour to trace the historical evolution of nursing care since its beginning as a distinct occupation. In the interests of time and space this will not be done here, though the effects of history on present thought will be discussed later. The interested reader should consult Fred Davis (ed.), *The Nursing Profession*, Wiley & Sons, New York, 1966, pp. 60-108 for one brief review of nursing history.

In fact, there appears to be plentiful evidence that unless the patient's psychological state is such that he believes he can and will get well, many recoveries will not be effected as expeditiously or as fully as they otherwise would be. To the extent that the nurse helps foster such a frame of mind, this puts the psychological care component of nursing on the borderline between care and cure. Nursing becomes even more a set of potentially curative activities when the patient's illness is mental rather than physical.

Nursing activities designed to provide psychological care are not classified here as cure activities because they are as yet very poorly developed.² While it is granted that the behaviour of the nurse towards the patient might improve his psychological state and thus further his cure, there is little agreement as to what particular nursing behaviour will have what particular effects on particular patients. At best there are a number of techniques for eliciting pertinent reactions from the patient so as to judge his psychological state. But research and theory on what specific procedures to use to improve that state are sketchy and frequently contradictory. Some general procedures are suggested for treating the more common causes of depression or anxiety in illness. These techniques are probably beneficial for many and, at worst, harmless for the remainder if they are properly applied.

Similarly, there are some general guidelines regarding procedures for handling certain common types of patients such as the senile, new mothers, young children. These common procedures include giving certain kinds of information about the patient's condition, the hospital and certain treatment procedures; counselling family and friends in the treatment of the patient both in hospital and out; and directing the patient to appropriate sources of help both within the hospital and without. They also include pointers on how to ask questions, demeanour in the presence of the patient, and strictures regarding the need for the nurse to show patience, empathy, and understanding in the presence of the patient.

The general nature of social scientific knowledge about interpersonal dynamics and their impact on the individual prevents these procedures from being made more explicit or completely effective. The field is much studied but, like most other branches of social science, it is very imprecise in its predictions of human behaviour. Also it is difficult to train nurses to practise even those limited number of procedures which are known and recommended.³ It has long been realized in other fields (such as teaching, business administration and social work) how difficult it is to change the behaviour of people by means of formal training programs. It appears that certain types of personalities are amenable to such training, while others either seem unable to practise the recommended behaviour patterns or do so in a very ineffective way. Such appears to be the case also in nursing. The nurse

²For a discussion of what is known about psychological care and its effects see Leo W. Simmons and Virginia Henderson, *op. cit.*, Chapters 12 and 13, and Bonnie Bullough and Vern Bullough, *Issues in Nursing*, Springer Publishing Co., New York, 1966, Part V.

³See Esther Lucille Brown, "Nursing and Patient Care", in Fred Davis, *op. cit.*, pp. 192-193.

12 *The Practice of Nursing*

may be told how she *should* behave towards patients but cannot always be made to practise the correct procedures. Moreover, the problem is often compounded by a work environment which severely inhibits even the most willing nurse from applying a full program of psychological care.

In spite of all these limitations, psychological care activities embodying both judgement of the patient's emotional state and procedures for improving it *do* form a part of the nurse's job.

Direct Cure

Judgemental and evaluative. In spite of very strict laws and beliefs on the part of physicians that the nurse must not diagnose or prescribe treatment for patients, the fact remains that she is the doctor's most valued assistant. She is his eyes, ears and hands for the twenty-three and three-quarter hours per day that he is not with the hospitalized patient. She is partially his head as well, because she must have some of the training that he has to be able to judge how the patient is responding to treatment. In a sense she often does take the first step in diagnosis, which is to make a preliminary and temporary judgement about how sick a patient is. On the basis of such a judgement she may or may not decide to call a physician or advise the patient to call one. Of course, in many cases this judgement is taken out of her hands, and she is simply instructed to call a physician when the patient's temperature, pulse, respiration or blood pressure goes over or under specified limits. In other cases, however, the change in condition is not manifested by the routine "vital signs", and the nurse must be able to detect subtle indications which are meaningful to only a well-trained and experienced person.

Incidentally, it is worth noting that outside the hospital, in industry, private practice, nursing homes, schools and remote areas where doctors are few and far between, it is not at all uncommon for some nurses to be virtually forced into breaking the law by making rough diagnoses of conditions and prescribing treatment for what they judge to be non-serious ailments. Illegal though such activities are, they are tacitly approved by the usually over-busy doctors and authorities concerned.

Procedures. The most common curative procedures engaged in by nurses are the administration of medications and the application of dressings; they often have to take the responsibility for dispensing medications as well, while on night duty, or at other times in small and remote hospitals.⁴ In addition, many other cure-type procedures are performed by nurses in emergency wards, operating and delivery rooms, and post-operative and intensive care wards. These involve duties ranging from directly assisting the physician in the classic Hollywood style (handing him instruments, wiping his brow), to applying anaesthetics and oper-

⁴The problem of nurses dispensing drugs is discussed in the Brief of the Registered Nurses' Association of Ontario to the Committee on the Healing Arts, 1966, pp. 25-27.

ating complex machinery (oxygen equipment, heart and lung machines, artificial kidney machines) sometimes with and sometimes without the physical supervision of physicians.

Adjunct Activities

The activities commonly performed by nurses which are adjunctive to or supportive of the direct care and cure activities illustrated above are numerous and varied. Some require the use of basic nursing training; some require skill and knowledge much beyond this; and others, little or no special training. These activities can be grouped under the following headings: administration, teaching, research, clerical activities, logistics.

Administration. Undoubtedly the largest and most significant adjunct activity to direct patient care and cure which nurses perform is the administration or management of nursing units. As will be discussed in detail later (page 34), there are several levels of administration commonly found in most nurse-employing organizations. Administrative responsibilities include employee recruitment and selection, budget setting, staff scheduling, planning nursing care, assigning work, and supervising work performance.

Teaching. Equally as important as administration in nursing is the activity of educating all classes of nursing personnel. Teaching is done in nursing schools, through R.N.A. programs, and through a wide variety of in-service programs carried out within employing organizations. It is done also in short courses and, most important, on an informal basis by thousands of staff nurses as they provide guidance and advice to students, newcomers and junior grade staff.

Research. If administration is the largest adjunct activity, in terms of the amount done and the number of nurses involved, the smallest is research. Nursing research is generally of two kinds: studies of nurses (their backgrounds, attitudes, educational patterns, and so on), and studies of nursing theory and practice. In Ontario there have been relatively more of the former than the latter, but the total of both is very small. The limited amount of research that is done is performed primarily by faculty and graduate students in university nursing schools and by the staff of organizations such as the Ontario Hospital Services Commission, the Registered Nurses' Association of Ontario, and the Canadian Nurses' Association.

Clerical activities. Much of the nurse's work consists of keeping records or supplying information in written form. Specifically, this means filling out forms for such things as admission; discharge or movement of patients; obtaining supplies, drugs and linen; laboratory tests; and recording information about the patient from doctors' orders or nurses' notes.

Logistics. Defined in its broadest terms, this refers to distributing or controlling people and things. Thus the nurse is often found fetching supplies, linen, medication or people (doctors, maintenance men, housekeepers); distributing or picking

up food trays, used supplies, soiled linen; and trying to control the flow of people such as doctors, technicians of all kinds, patients and their visitors, all of whom have access to her work place.

How Nurses Spend Their Time

The previous section discussed the nature of nursing activity in general. This section will attempt to show in more detail what each of the main classes of nurse does and how much time is spent in the various types of activity. Some comparison will be made also of activities as they vary between Ontario and other provinces or countries, and between different types of employing organizations. This information is drawn from published material from a variety of sources, and from our own limited observations and interviews conducted in a sample of employing institutions throughout the province.

Nursing in Hospitals

Since the early 1960's the nursing consultants branch of the Ontario Hospital Services Commission has been carrying out a series of activity studies on how the personnel in nursing departments spend their time. To date they have studied about 170 separate nursing units located in sixty-two different hospitals throughout the province. Recently the Research and Statistics Branch of the OHSC has started to summarize the results of these studies so as to provide a broad picture of the utilization of nursing personnel on a province-wide basis. Some of the initial results of this summary study were made available to us prior to their publication and are discussed below.⁵

Procedure. The activity studies were performed only in those hospitals which requested them. This in itself, of course, could be a biasing factor leading to the exclusion of those hospitals which felt they were using their staff so effectively that they did not need a study and those which were so poorly run that they were afraid of having a study carried out. In any given hospital, the procedure was to select members of the supervisory nursing staff to act as observers. These observers were trained by the visiting OHSC nursing consultants in the method of carrying out an activity sample and recording observations. Ample instruction as to the nature and purpose of the study also was provided to members of the hospital administration and the particular nursing units to be studied.

Method. Without going into detail regarding the nature of work sampling methods,⁶ the basic approach the observers used was to note the activities engaged in by unit personnel once every quarter hour and to record these in a prepared "Observer's Record". Appendix I at the end of this report presents material on the coding system used in classifying activities on the Observer's Record. It is interesting to note several features of this system.

⁵For the final report of this summary see *Evaluation of the Activities of the Nursing Unit Personnel, 1956-1965*, Ontario Hospital Services Commission, September 1968.

⁶For a simple description of the method see "Nursing Activity Study", an unsigned article in *Canadian Hospital*, March 1963.

No distinction is made between registered and non-registered nursing assistants, or between registered and non-registered professional staff nurses, even though the hospitals themselves may make such a distinction in their job descriptions. No attempt was made in the study to estimate whether direct patient care given by a staff member was above, below, or at her level — that is, something she should or should not be doing, given her training and experience. Thus these studies shed no light on the frequent charges that R.N.'s and R.N.A.'s are underutilized or overutilized with respect to the procedures they perform on patients. The judgement that one is performing "above" or "below" one's level in areas *other* than direct patient care is based on deviations from the written job description for the position being observed. No judgement is made by the observers as to whether these job descriptions are "proper". For example, if the job description for a nursing assistant said she was responsible for preparing certain supplies, then this activity would be classified by the observer as nursing assistant level, even though many experts might argue that such activities should be done not by this group but by some other person such as a central supply officer.

Though the job description governs coding by level for most activities, there is a deviation from this practice in the case of clerical, dietary, housekeeping and messenger activities. Irrespective of whether the job description or established practice in the hospital requires that such activities be performed by nursing staff, the implicit value judgement is that they are not properly the work of trained nursing personnel such as supervisors, professional staff or nursing assistants; hence they are classified as separate "levels" of work.

Results. The main questions to answer from the data obtained in the activity studies are the following:

To what extent are the members of nursing units performing (non-direct patient care) activities above and, particularly, below their level?

To what extent are personnel who are charged primarily with providing patient care occupied in the ancillary tasks of clerical, housekeeping, dietary and messenger activities which, ideally, should be performed primarily by ward clerks, messengers, and members of the housekeeping and dietary departments?^{7, 8}

⁷The data on these questions provide only the most obvious answers. Of course, there is a vast array of additional information to be obtained from the study. Much of it, however, is somewhat ambiguous in terms of the general conclusions which can be drawn about the less than optimal use of nursing resources. This is not to say that such data are not very useful when interpreted by skilled nursing consultants in the light of the conditions and demands in the specific unit and hospital studied.

⁸The housekeeping department in hospitals is independent of the nursing department, and is responsible for the general care and maintenance of the buildings, non-medical equipment, and furnishings. The dietary department in hospitals normally performs the function of preparing food for patients and staff. It also is responsible for the distribution of food to patient areas, but not always to the patients themselves.

TABLE 1
Numbers of Nursing Personnel Studied by Position Title and Nursing Unit
OHSC Activity Studies, 1960-1967

Type of Personnel	Public Active Treatment Hospitals																								Public Hospitals— Chronic Care		Totals	
	Surgical			Medical			Medical & Surgical			M, S, M & S 2-14 yrs.			Paediatric			General			Post- partum			Delivery			Nursery			
	Day	Eve.	Day	Eve.	Day	Eve.	Day	Eve.	Day	Eve.	Day	Eve.	Day	Eve.	Day	Eve.	Day	Eve.	Day	Eve.	Day	Eve.	Day	Eve.	Day	Eve.		Day
Supervisor	3	2	2	1	4	2	9	5	—	—	2	1	5	4	6	4	5	3	—	—	—	—	—	—	—	—	36	22
Head Nurse	33	9	41	17	21	10	95	42	4	3	8	5	13	6	9	4	11	4	8	10	8	10	243	110	—	—	243	110
Prof. Staff Nurse	33	33	42	40	21	21	96	92	2	4	10	10	13	13	10	10	10	11	10	12	10	12	247	246	—	—	247	246
Nursing Asst.	31	33	42	48	22	22	96	100	4	4	12	10	13	10	9	7	10	11	13	12	13	12	252	257	—	—	252	257
Orderly	29	22	33	35	17	17	83	80	1	1	1	—	—	—	—	—	—	—	11	10	11	10	175	169	—	—	175	169

SOURCE: Figures based on preliminary summary tabulation of results of OHSC Nursing Activity Studies prepared by the Statistical Research Division, OHSC.

TABLE 2
Percentage of Time Spent in Activities (Other than Direct Patient Care) "Above" or "Below" Level of Work

Department	Nursing Supervisors		Head Nurses		Prof. Staff Nurses		Nursing Assistants		Orderlies	
	Below level	%	Below level	(no time spent above level)	Above level	Below level	Above level	Below level	Above level	Total
Surgical—Day	45.3		23.6		.2	13.2	13.4	1.1	24.8	25.9
—Evening	100.0		17.2		.2	9.3	9.5	2.0	25.2	27.2
Medical—Day	35.0		26.4		.1	11.4	11.5	1.3	21.5	22.8
—Evening	25.6		30.1		.4	8.8	9.2	1.4	23.2	24.6
M & S—Day	42.2		26.0		.2	14.4	14.6	2.2	23.6	25.8
—Evening	10.8		42.7		.1	10.1	10.2	2.1	28.1	30.2
M, M & S—Day	41.3		25.3		.2	12.8	13.0	1.4	23.2	24.6
—Evening	53.5		29.0		.3	9.2	9.5	1.8	25.1	26.9
Postpartum—Day	20.4		26.5		.1	12.6	12.7	1.7	16.7	18.4
—Evening	27.5		10.8			11.8	11.8	1.3	24.8	22.1
Delivery—Day	36.9		37.7		.3	14.4	14.7	2.2	27.3	29.5
—Evening	38.7		35.8			11.6	11.6	.3	25.9	26.2
Paed. —Day	*		15.7		.1	11.2	11.3	.3	10.1	10.4
2-14 yrs.—Evening	*		9.7		.1	8.4	8.5		9.7	9.7
Paed. —Day	11.6		22.9		.8	6.1	6.9	2.2	16.5	18.7
(Gen.)—Evening	*		43.0		.1	4.9	5.0	2.5	18.7	21.2
Nursery—Day	8.7		46.7		.1	9.8	9.9	2.8	9.9	12.7
—Evening	*		*		.1	7.0	7.1	3.1	5.3	8.4
Chronic—Day	*		45.1		.6	18.1	18.7	.9	14.1	15.0
—Evening	*		44.3		.1	14.1	14.2	.2	16.1	16.3
Average all units	30.2		29.6		.3	12.4	12.7	1.6	18.8	20.4
—Day										
Average all units	42.7		29.2		.1	9.5	9.6	1.5	19.8	21.3
—Evening										
Average all units	36.4		29.4		.2	11.0	11.2	1.5	19.3	20.8
Day and evening										

* Too few observations to be meaningful.

SOURCE: Figures based on preliminary summary tabulation of results of OHSC Nursing Activity Studies prepared by the Statistical Research Division, OHSC.

TABLE 3
Percentage of Time Spent in Specific "Non-nursing Activities" by Main Classes of Nursing Personnel

DEPARTMENT	SUPERVISORS				HEAD NURSES				PROFESSIONAL STAFF NURSES				NURSING ASSISTANTS				ORDERLIES			
	Clerical %	House-keeping %	Diet-ary %	Mess-enger %	Total %	C %	H %	D %	M %	Total %	C %	H %	D %	M %	Total %	C %	H %	D %	Total %	
Surgical—Day	3.6				3.6	10.7	2	1.5	1.0	13.4	3.2	1.5	4.0	1.2	9.9	2.2	8.1	11.8	2.2	24.1
	9.9				10.3	4.8	3	3.7	2.1	10.9	4.2	3	2.8	.6	7.9	2.6	3.0	16.7	2.0	24.3
Medical—Day	.6	.3			.9	12.8	3	1.2	.6	14.9	3.6	1.0	3.2	1.0	8.8	1.7	5.0	11.8	2.7	21.2
					1.6	6.3	2	2.3	2.3	11.1	3.9	.4	2.8	.5	7.6	1.9	2.7	16.7	1.8	23.1
M & S—Day	1.8	1.8	4.0	.3	7.9	10.0	.8	2.5	1.1	14.4	3.4	1.4	4.4	1.0	10.2	1.7	7.1	12.4	2.1	23.3
	2.7				2.7	8.6	1.0	3.4	.4	13.4	3.8	.4	3.3	.5	8.0	3.0	2.0	20.5	2.0	27.5
M, S, —Day	2.2	.7	1.2	.1	4.2	11.5	.4	1.6	.9	14.4	3.4	1.3	3.8	1.1	9.6	1.8	6.5	12.0	2.4	22.7
M & S—Evening	4.7		1.2		5.9	6.4	.5	3.1	1.7	11.7	4.0	.4	2.9	.5	7.8	2.4	2.6	17.7	1.9	24.6
Post—Day	1.3	.4	1.3		3.0	11.3	.6	1.3	.7	13.9	3.6	1.3	2.1	.7	7.7	4.2	3.4	6.0	1.6	15.2
Partum—Evening		5.0			5.0	4.1		5.4		9.5	4.6	.4	3.3	.4	8.7	2.4	1.7	13.6	1.4	19.1
Delivery—Day	1.8		1.1		2.9	6.9	1.2	1.1	.6	9.8	3.6	3.2	.8	.6	8.0	1.8	13.9	3.4	5.2	24.3
—Evening	3.2	.9	3.7	.5	8.3	5.7	.9	.9		7.5	2.3	1.9	1.3	.3	5.8	.7	8.2	6.5	2.3	17.7
Paed. —Day	*	*	*	*	*	8.8	1.2	.1	.8	10.9	3.6	1.5	2.0	1.8	8.9	.5	2.1	2.6	4.4	9.6
2-14 yrs.—Evening	*	*	*	*	*	4.4				4.4	3.5	.8	2.8	.7	7.8	1.1	3.7	2.0	2.9	9.7
Paed. —Day	—	1.2	1.1	2.9	5.2	6.6	.3	1.9	.5	9.3	1.5	1.1	1.4	.5	4.5	.6	4.5	9.3	1.8	16.2
Gen. —Evening	*	*	*	*	*	2.5		3.3	.8	6.6	2.0	1.0	.8	.5	4.3	1.3	3.5	11.5	1.8	18.1
Nursery—Day	—	—	—	—	—	4.0	2.2	.3	1.0	7.5	2.6	2.7	.1	1	5.5	1.8	5.8	2	.8	8.6
—Evening	*	*	*	*	*	*	*	*	*	*	.8	1.6	.3	.1	2.0	.7	2.4	.9	.2	4.2
Chronic—Day	*	*	*	*	*	11.2	.3	3.3	2.2	17.0	4.5	1.1	7.4	1.5	14.5	.4	2.1	10.6	.8	13.9
—Evening	*	*	*	*	*	3.1	.3	5.6	1.5	10.5	2.0	.5	9.2	.2	11.9	.5	2.1	12.4	.8	15.8
Average measured units (all days)	1.4	.6	1.1	.4	3.5	9.4	.7	1.5	.9	12.5	3.3	1.6	2.9	.9	8.7	1.6	5.8	8.0	2.4	17.8
Average measured units (all evenings)	3.4	.8	1.3	.1	5.6	5.1	.4	3.1	1.0	9.6	3.1	.8	2.9	.4	7.2	1.7	3.2	11.8	1.7	18.4
Average (day and evening)	2.3	.7	1.2	.3	4.4	7.2	.5	2.3	1.0	11.1	3.2	1.2	2.9	.6	7.9	1.6	4.5	9.9	2.1	18.1

*Too few observations to be meaningful.

SOURCE: Figures based on preliminary summary tabulation of results of OHSC Nursing Activity Studies prepared by the Statistical Research Division, OHSC.

Table 1 shows the number of personnel observed in the total number of studies summarized by the OHSC, broken down by job classification and type of nursing unit.

Table 2 summarizes the percentage of time spent in activities which the observers, using the coding system described in Appendix I, judged to be not of the level of work indicated in job descriptions for each job classification (with the exception of direct patient care activities, which were not differentiated by level). It can be seen that nursing personnel spend, on average, anywhere from 11 per cent to 36 per cent of their time out of their level, with supervisors and head nurses heading the list and professional staff nurses at the bottom. Not only is there considerable variation between job classifications in time spent on out-of-level work, but the variation is even greater depending on the type of nursing unit in which the staff are employed. It appears that the greatest amount of out-of-level work for all classes occurs in medical, surgical, and combined medical-surgical units. This is probably because of the ever-changing composition of such units in terms of the type and severity of cases admitted to them.

Table 3 indicates the amount of time that the various classes of nursing staff spend in clerical, housekeeping, dietary and messenger activities — activities which, according to virtually every current expert on nursing problems, are better performed by non-nursing personnel so that the quality and quantity of patient care can be improved. One might argue that a certain proportion of these non-nursing activities inevitably must be performed by trained nursing staff, simply because some of them are intrinsic to and inseparable from major patient care activities. If one looks at the detailed listing of such activities in the coding system (Appendix I), however, it is difficult to envisage many circumstances under which the specific activities listed could not be separated from nursing activities if attention were paid to the organization, staffing and training of ancillary employees (ward clerks, housekeeping, dietary and messenger staff).

Nursing supervisors do the least ancillary work (4.4 per cent on average). Of that which they do, clerical work is the most frequent, ranging from zero to a high of 10 per cent on medical wards in the evening, with an average of 2.3 per cent. Head nurses spend an average of 11 per cent of their time on the specified non-nursing activities, and again clerical work is the most common of them. Here the range is from 2.5 per cent to about 13 per cent, with medical, surgical, post-partum and chronic care units requiring the most time and paediatric, nursery and delivery units the least.

Professional staff nurses spend an average of about 8 per cent of their time on ancillary tasks, the most common being clerical and dietary activities. The range here is from a fraction of one per cent to a high of 9.2 per cent on dietary

activities in chronic care units during evening shifts. In general, there is more non-nursing work on the day shifts. This type of work is least frequently done in general, paediatric and nursery units and most frequently done in chronic care units.

Nursing assistants spend almost a fifth (18 per cent) of their time on the ancillary non-nursing tasks, with dietary activities taking up the lion's share of the time (12 per cent). These activities occur most often in combined medical-surgical units on evening shifts (27 per cent) and least in nursery units on evenings (4 per cent).

Orderlies are among the most diversely organized and trained work groups doing nursing in Ontario hospitals. There seems to be no clear-cut policy in the province as to whether these men are responsible for nursing the sick or are just odd-job men. This ambiguity is reflected in the survey results, which show an average of about a quarter of their time spent in the ancillary tasks, ranging from 8 per cent (chronic care units, day shift) to 62 per cent (paediatric units, evening shift). The activities most frequently performed are dietary and messenger tasks.

General Comment on the OHSC Studies

While this summary of the OHSC nursing activity studies reveals considerable underutilization of nursing resources among the main categories of personnel charged with attending to patients, it should be recognized that it is basically a very conservative and in some ways misleading statement on the degree of deviation from optimal utilization. Because they do not attempt to distinguish between levels of direct patient care and because they implicitly accept each hospital's job descriptions as satisfactory definitions of what each level of personnel should do, the studies offer no indication of how much improvement is needed in these two areas.

The studies are potentially misleading, in that one might conclude from them that the answer to better use of nursing personnel is to define rigidly the activities of each class and level, and to make every effort to prevent staff from doing out-of-level or non-nursing work. This would be a highly erroneous conclusion.

Caring for patients involves much teamwork and cooperation, and the activity studies in no way suggest that this could or should be otherwise. What *can* be done, however, is to organize patient groupings, physical layouts, technical systems and staffing patterns so as to maximize the amount of time a person spends doing what she is best qualified to do and to minimize the need for doing other things.

Cross-National Comparisons of Nursing Activities

Interestingly, earlier studies done in the United States confirm the OHSC studies in almost every detail.⁹ In general, however, the results of these studies are "worse"

⁹The major studies of this kind done up to the late 1950's are well summarized and critically discussed in Leo W. Simmons and Virginia Henderson, *op. cit.*, Chapter 11.

than the OHSC's, showing more of the nurse's time spent in ancillary and out-of-level activities and less time spent with the patient in direct nursing care.

Many of the American studies go beyond those done in Canada, in that they attempt to measure the amount of overlap in direct patient care activities between R.N.'s and nursing assistants. The results show these two groups doing about 50 per cent of their work in common. Simmons and Henderson hasten to point out how misleading such results can be and in the process justify the OHSC's decision not to attempt to discriminate who does what directly for the patient. The main consideration is that the degree of illness should determine the level of person who nurses a patient. If a patient is extremely ill, the greatest skill and knowledge might be required to perform the most simple procedure. The need for this special competence declines for less severe cases and as the severe cases progress in recovery. In addition to the fact that the patient's needs make it difficult to judge who should give what care, there is the fact that a professional nurse, in the process of carrying out a truly professional nursing activity, might at the same time perform all sorts of non-professional services such as positioning the patient, straightening his pillow or bed clothes, getting him a glass of water. It is inconceivable that she should *not* do these things for the patient, even though activity study methods might catch her in the act of doing them.¹⁰

Incidentally, a further reason why one is much more likely to find R.N.'s and nursing assistants overlapping in the U.S. than in Canada is simply that there are larger numbers of nursing assistants in the U.S., the U.S. ratio being roughly 60 per cent to 40 per cent R.N.'s, as compared with the opposite ratio here. This means that nursing assistants are given more to do, while the R.N. becomes much more of an overseer and performer of very special technical tasks. Since neither of these activities takes up a great deal of time, the R.N. spends the rest of her time doing the same work as the R.N.A. — particularly for the more seriously ill patients.

By way of comparison, it is interesting to note very briefly the situation in the United Kingdom and in much of Europe. There the growth in the use of nursing assistants and auxiliary help has been much slower. Consequently, the equivalent of the registered nurse behaves in a much more traditional fashion — providing *all* the care, both skilled and unskilled, for the patient, *plus* a larger proportion of the housekeeping, clerical, dietary and messenger activities (though often many students are available to do these chores, since the educational system is closer to the apprenticeship type than that in either the U.S. or Canada).

One final comment should be made concerning the significance of activity studies of nurses. While they are useful in indicating some of the most obvious misuses of the resources of trained personnel, they do not suggest the optimal

¹⁰*Ibid.*, pp. 271-277.

patterns for organizing, staffing and defining the jobs of the various classes of nursing unit personnel; nor do they address themselves directly to the question of quality of care given. At best they suggest that improvements could be made in resource utilization and, as a result, the implication is that some improvement in quality of care would be obtained. Some of the types of improvements that could be made and the dire need for more research into the actual effects on the patient of various patterns of care will be discussed in later sections of this chapter.

Observations of Research Staff on Field Trips

While we did not in the present study have the time or competence to do detailed studies of nursing activities in the various hospitals we visited, we did inquire how the activities in nursing units were organized and distributed. In this way we discovered, as did the OHSC studies, an extremely wide variation in the way the various classes of personnel were used. In most cases, nursing directors and supervisors readily admitted that a thorough analysis of the duties, responsibilities and interrelationships of all personnel involved in the operation of nursing units would undoubtedly yield significant improvements in the quantity and quality of patient care. This broad and deep analysis was felt to be not feasible, however, due to problems of cost, outmoded physical layouts or equipment, or resistance on the part of the administration and other department heads.

In one case, we observed a new hospital where a heightened sensitivity to the optimal use of nursing resources, coupled with the latest technological innovations in communications and distribution, had reduced the time nurses spent on paper work, housekeeping, fetching and carrying, and dietary activities almost to zero. In addition, a highly sophisticated system of team nursing, combined with provision of clinical specialists as consultants, has gone far in overcoming the problem of overutilization or underutilization in direct patient care in this hospital. The conditions which facilitate the creation of an improved situation such as this will be discussed in the section on decision-making.

Public Health Nursing

The work of the nurse in public health varies somewhat, depending on the type of public health organization employing her. Generally speaking, employer organizations can be grouped into two broad categories: government agencies (municipal and provincial), and private and semi-private health agencies of various types.

The following description of the specific nursing activities involved in various public health settings is based primarily on information provided in interviews with some of the nursing officials and university faculty specializing in public health in the province.

1) Public Health Nursing in Government Agencies

The main government employers of public health nurses are municipal and county health units. In general, these units are charged with identifying public health problems; prevention of illness through education; immunization and inspection of

sources where disease might originate; and aiding in the elimination of existing common health problems in the community. The specific services provided by these units are numerous and vary from one to another. However, the major activities performed almost everywhere which involve nursing personnel are clinics for maternal and child care; communicable disease control; health care in schools; and certain home visiting services. At the provincial level in the Department of Health, Public Health Division, there are nursing consultants for the local public health agencies as well as nursing personnel attached to sections such as occupational health, maternal and child health, and medical rehabilitation and chronic care.

The classes of nursing personnel in public health units (aside from administrative staff) are public health nurse (an R.N. with a university degree, or a one-year diploma or certificate in public health nursing); R.N. (non-degree, non-special certificate holder); and registered nursing assistant. The major functions of the specially trained public health nurse are evaluating nursing needs in the particular segment of the unit to which she is attached; planning the nature of nursing service to be given; and conducting various programs designed to educate the public on health matters. She does this both independently and in conjunction with other health specialists in the agency and community. In addition she gives care to non-hospitalized individuals and families, and helps in immunization and certain inspection programs.

In some of the larger and wealthier units where the public health nurse is to be found, certain trends are taking place in public health agency programs: inspecting, and sometimes giving care in, nursing homes, old age homes, centres for infant and child care, and centres for occupational health; providing follow-up observation and after-care for recent mental hospital patients; conducting family planning clinics; developing liaison between a variety of community agencies and hospitals to facilitate continuing care of patients after discharge from hospital; and working with other social agencies in trying to rehabilitate long-term multi-problem families on welfare.

The non-specialized R.N. in public health nursing is in an ambiguous position similar to that of the R.N.A. in hospitals. In general, there has been a reluctance to employ large numbers of straight R.N.'s, on the assumption that their training has been inadequate for public health work. Since there has always been a shortage of qualified public health R.N.'s, however, they are used — their numbers varying from locale to locale, depending on budget conditions and availability of qualified public health nurses. The ambiguity lies in how to use them. As will be discussed later, this debate is current and growing in significance. At present it appears that R.N.'s who stay in the municipal public health area, if they do not obtain specialized formal training, acquire a form of training-on-the-job and go on to do substantially the same work as specialized public health nurses. They give direct care to patients in schools, clinics and homes, and participate in various

disease detection or prevention programs. They also help give instruction on health matters to individuals, families and groups, and work with public health nurses in establishing nursing needs and planning care. R.N.'s who are new to public health work perform mostly routine nursing care procedures — giving medications, injections and dressings; giving instruction on self-care; and evaluating patient condition mainly in schools or clinics. They receive considerable direct supervision and guidance from qualified public health nurses.

The registered nursing assistant in municipal public health work is even rarer than the non-specialized R.N. Where R.N.A.'s are used, they are found primarily in clinics, schools and child or occupational health centres, where they are under the continuous direction and supervision of R.N.'s. Their activities are basically the same as those performed in hospitals: housekeeping duties; obtaining, preparing, and maintaining supplies and equipment; and doing other kinds of routine care procedures.

2) *Private and Semi-private Agencies*

These employers of nursing personnel are many and varied. They include such organizations as Children's Aid Societies, Ontario Society for Crippled Children, Canadian Cancer Foundation, Alcoholism and Drug Addiction Research Foundation, Canadian Mothercraft Society, St. John's Ambulance Association, the Red Cross, Canadian National Institute for the Blind, and visiting nurse associations. Most of these organizations, with the exception of the visiting nurse associations, operate from clinics or centres to which users of their services come. Because of this most of them tend to use R.N.'s without specialized public health training. These personnel give treatments, instruction and help in rehabilitation, usually under the supervision of specialized public health nurses.

By far the largest employer of nurses among the private agencies are two major visiting nurse organizations, the Victorian Order of Nurses and St. Elizabeth Visiting Nurses Association. The main job of these organizations is to provide nursing care to people in their own homes (in contrast to the primarily preventive, educational and clinic-based nursing services provided through government health agencies). In addition, since the commencement of the Home Care Programme, sponsored and financed by the Ontario Hospital Services Commission, both agencies have assumed some responsibility for its administration on a contract basis. This has necessitated their procuring certain services other than nursing, such as physiotherapy and homemaking (domestic work for invalids).

The distinction between qualified public health nurses, R.N.'s and the few R.N.A.'s employed by visiting nurse organizations is primarily one of responsibility. R.N.'s visit homes alone to perform specific procedures specified by a public health nurse. R.N.A.'s travel with public health nurses on their visits or work under their direct supervision in the few clinics (such as those for well babies) run by the agencies. The public health nurses are responsible not only for giving treatment

specified by the physicians, but also for independently planning a total nursing care program for each of their patients. They are not permitted to start intravenous therapy, do the first catheterization on male patients, or administer drugs which have not been approved by the medical advisory committee of their branch.

Since supervisors could not possibly oversee the nurses' activities in each of the homes they visit, their work offers possibly the greatest amount of independence in the field of nursing.

3) *Trends in Public Health Nursing*

According to those interviewed, the major trend in public health care in North America is towards more varied and increased service. There appears to be a continuing emphasis on preventive medicine, in which attempts are made to identify and remedy health hazards before they cause sickness. This is coupled with increasing efforts both to reduce the number of cases requiring hospitalization by means of treatment in the home and to shorten the length of hospital stays by early discharge combined with follow-up care in the home. There is also growing concern with detecting and treating mental health problems in the community.

Nursing for Independent Employers

So far we have discussed nursing in settings which are partially or wholly controlled by some branch of government (the exception being the visiting nurse organizations, which nevertheless perform a direct and needed community service and are non-profit organizations partially financed by government money). There remains, however, a large variety of nurse employers who are not controlled or financed to any appreciable extent by government agencies. The main employers in this category are 1) private business organizations; 2) private nursing homes; 3) private doctors' clinics and individual offices; and 4) individuals employing nurses for private practice. The main characteristic shared by these private employers is that each has full control over which class of nurse he chooses to employ and, within the broad limits of the Nurses' Act, which type of duties and responsibilities he can expect her to perform. In this way private employers differ from employers discussed previously, in that the latter all have professional nurses who hold some position or positions of authority in the decision-making structure of the organization, and who help to decide what is to be done by various types of non-supervisory nurses. Thus in these organizations there is much greater consistency and expert control over how nurses are utilized than among the private employers.

Businesses and other large employers, for example, may choose to hire a public health specialist or degree R.N., a diploma R.N., an R.N.A., or someone with either no registered status or no formal nurse training at all. Such people, whatever their training, may have very wide discretion in what they do for the people who come to them for help.

The activities performed by *industrial nurses* range from simple first aid to complex semi-medical duties such as giving placement examinations, periodic check-ups, blood tests and urinalysis; between these two extremes are routine types of nursing care (administering medications, massages, simple physiotherapy, assisting in emergency surgery). They may be required to participate in identifying and eliminating health hazards, and in setting overall company policy on what health services the company will provide. In almost all cases they have considerable responsibility in deciding whether or not to refer a patient to a physician.

Nursing in *private nursing homes* is typically very similar to the routine nursing care provided by R.N.A.'s and non-registered nurse's aides in hospitals. On the other hand, dealing as they do primarily with the aged, chronically ill or long-term rehabilitative cases, they may encounter emergencies in which highly skilled evaluation and care procedures are necessary. The few R.N.'s employed in nursing homes are usually in an administrative or supervisory capacity and, for that matter, so are a large proportion of the R.N.A.'s. In fact most of the direct nursing care in nursing homes is provided by non-registered practical nurses.

In the case of nurses employed by *individual doctors or doctors grouped into private clinics*, the limitations placed on the nurses' activities are naturally greater due to the employers' knowledge of both medicine and nursing. Here the problem tends to be one of underutilization of the nurses' training rather than requiring them to accept responsibilities for which they are not trained. According to information supplied by nursing officials interviewed, too many R.N.'s, for example, are used by doctors primarily as receptionists and clerks, while most of the medically relevant patient care activities could be performed by someone with R.N.A. or even practical nurse training. Again, however, there are rare emergencies when complex, highly skilled nursing service is required. The likelihood of this depends largely on the nature of the doctor's practice.

Private duty nursing used to be the backbone of the nursing profession, with the majority of trained nurses in this form of practice. As will be seen in Chapter 4 of this report, the number of nurses in private duty nursing today is only a small percentage of the total. Persons offering themselves as private duty nurses again may range from the most highly trained R.N.'s to diploma R.N.'s to R.N.A.'s to non-registered people with some type of nurse training, to the helpful neighbour of yesteryear who would cook, clean, and provide the simplest care for a person while he was sick. The activities of private duty nurses range from complex post-operative care in hospitals through normal routine care in hospitals to convalescent, rehabilitative and chronic care provided in the patient's home or occasionally in a nursing home. The unique feature of the work, of course, is that the nurse tends one patient only for her entire daily work period, and is hired and paid directly by the patient or his family.

Summary

In this section we have been trying to describe what the practice of nursing is all about and some of the trends in the main settings where nursing is currently practised. It was seen that the essence of nursing activity is providing physical and psychological care for the sick and aiding (along with many other occupational groups) in the attempt to prevent or cure sickness. Though this much is clear, the detailed description of nursing is immensely diverse and ambiguous. While there are three main classes of trained nurse — R.N., R.N.A. and non-registered aides (and several subclasses within the R.N. group) — there is little uniformity in what each class or subclass does, both within similar employment settings and between different settings. There is also a considerable overlap in activities between classes and, for that matter, between nurses and other occupational groups. Given that this is a relatively accurate, albeit very broad, description of the current state of nursing practice, the question arises of whether or not this situation is desirable and what changes (if any) should be made. The next section presents what we found to be the main opinions on these questions held by organizations and individuals concerned with nursing. Following this, we will discuss where the decisions are made that have created the present situation and analyze the forces that have shaped it.

Opinion on Current Conditions

Virtually all those who offer their views on nursing start with the implicit or explicit belief that the prime goal of nursing (and, for that matter, all the health occupations) should be to maximize patient welfare. All appeals for change are predicated on the assumption that the change will enhance the efficiency and effectiveness of attempts to maintain or restore health. Given this common beginning, the views of all interested parties then proceed in a variety of directions — some complementary, but many in sharp conflict with one another.

Views of Officials of Professional Associations

Areas of Agreement

On certain questions in the area of nursing practice there is remarkable unanimity among spokesmen for bodies of professional nurses in Canada and the United States (groups such as the Canadian Nurses' Association, provincial nurses' associations, the American Nurses' Association, the National League of Nurses). The broader and more general the opinions expressed, the greater is the unanimity among these groups. When one gets down to detail regarding how many classes of nurse there should be and what each should do, the views start to differ widely between nursing association spokesmen in the U.S. as against Canada, between one association and another, and between "education-oriented" as opposed to "practice-oriented" nursing spokesmen.

The basic concerns of virtually all official spokesmen are twofold: to upgrade the quality of patient care, and to upgrade the status of the nursing profession. On

examining the suggested means for attaining these objectives, we cannot always ascertain which of them are aimed at improving quality and which at improving professional status. In fact spokesmen maintain, as do the leaders of every profession, that client or patient welfare and professional standing go hand in hand. What are the most widely shared beliefs of direct relevance to nursing practice?

The uniqueness and independence of nursing. It is maintained that nursing can and should be thought of as a body of theory, knowledge and skills which is unique and independent relative to the content of other health occupations.¹¹ A corollary to this belief is the conviction that more attention must be paid to nursing practised in non-hospital settings where the nurse is less dependent on, and less subordinate to, doctors and non-nursing administrators.

The abolition of non-nursing activities. The nursing profession must strive to divest itself of non-nursing activities and must vigilantly resist the imposition of duties and responsibilities properly performed by other health-related professions and occupations. In particular, nurses should no longer have to perform many clerical and secretarial activities, the fetching and carrying of supplies, messenger duties, and housekeeping and dietary activities in the patients' immediate environment. In addition they must resist having to do regularly the work of pharmacists, physiotherapists and laboratory technicians when these personnel are not on duty (evenings, nights, weekends and holidays).¹²

Importance of psychological care. There is a very high degree of unanimity also concerning the need for nurses to provide more and better psychological care. At least as much attention must be paid to the patient's mental and emotional state as to his need for physical care.¹³

Need for clinical specialization. Most spokesmen agree that there should be some form of clinical specialization in nursing beyond the existing specializations of public health, teaching and administration. Disagreement arises over who should specialize (only degree R.N.'s or any R.N.?) and by whom the training should be provided.¹⁴

¹¹See, for example, Virginia Henderson, *The Nature of Nursing*, Macmillan, New York, 1966, p. 16.

¹²See School of Nursing, University of Western Ontario, Brief to the Committee on the Healing Arts, 1967, pp. 11-12.

¹³This view is elaborated in a vast array of sources. Among the best is Esther Lucille Brown, *Newer Dimensions of Patient Care*, Sage Foundation, New York, 1965, Part 3.

¹⁴See School of Nursing, University of Western Ontario, Brief to the Committee on the Healing Arts, *op. cit.*, p. 12.

Need for nursing research. Finally, there is general agreement that there is a pressing need for more and better nursing research, especially in evaluating the effectiveness of specific practices.¹⁵

Areas of Ambivalence and Disagreement

Given the above areas in which most major nursing spokesmen agree, there remain a number of basic questions on which there is still substantial ambivalence or disagreement.

For example, though it is agreed that nursing should consist of a unique and independent body of knowledge, it is not clear exactly which of the present components of nursing are unique and which are more properly treated as part of other health disciplines.

A number of spokesmen submit that the primary unique function of nursing is evaluating, planning, instructing in and giving care so as to promote or maintain health. As well as emphasizing care, these officials warn against the nurse being thought of as primarily a "handmaiden" of the physicians. Fearing that the nurse's job might be turned into that of an assistant doctor, composed of ever-increasing numbers of cure activities under the total control and supervision of the physician, they resist the delegation by physicians of any more of their duties.

Against those urging that the cure side of nursing be kept as a secondary and non-expanding function are those who are not at all reluctant to take over new cure functions from physicians. These spokesmen propose that nurses have an equal voice in deciding which of these functions are to be delegated, and in working out the specific procedures to be followed in performing each function.

Though there is general agreement that the nurse should be spending more time at the bedside (instead of doing non-nursing activities), there is considerable disagreement as to which class of nurse should be there and what, exactly, each class should be doing.

American Nurses' Association spokesmen and many of their Canadian counterparts attempt to make a distinction between "professional nurses" and "technical nurses" (plus nurse's aides). The basis of this distinction between professional and technical is the possession of a university degree. There are different opinions as to what each class should do. One group (the largest) maintains that professionals should be primarily supervisors, teachers and consultants, who advise and guide the actual bedside technical nurse and work with representatives of other health disciplines in planning broad policy and procedure. The technical nurse should do the actual bedside work and should make lower-level judgemental

¹⁵See University of Toronto School of Nursing, Brief to the Committee on the Healing Arts, November 1966, pp. 11-13.

and evaluative decisions about specific patients; but she should have no overall concern with theory or general policy formulation. The nurse's aide should help the technician by performing various procedures at her direction.

Another basis for distinguishing between professional and technical nursing is the type and severity of the illness. Professionals should handle patients with complex nursing needs — patients for whom it is difficult to judge and evaluate care and cure problems, and upon whom difficult nursing procedures are performed. Technicians should handle less complex cases and aid the professional in complex cases. Nursing assistants should aid both groups as needed. It should be mentioned that those who see professionals as actual practitioners rather than *just* teachers, supervisors and consultants, tend also to see the degree-holding professionals as the group from which teachers, supervisors and consultants should be drawn. The only real difference is that in one case the professional does not actually do much bedside nursing and in the other she *may* do certain types of it.

Another area of ambiguity of viewpoint among nurses' association spokesmen is the role of the registered nursing assistant. Some officials in Canada are of the opinion that this class of nurse should be abolished (given that sufficient R.N.'s could be trained to replace the R.N.A.'s).¹⁶ Other Canadian and many U.S. spokesmen, on the other hand, see a continuing role for the R.N.A. and the formally prepared orderlies as staff who perform the most simple and routine nursing activities under the guidance of the R.N. Note, incidentally, that these advocates of the latter view are as eager as any to get the R.N. "back to the bedside", but they prefer that she be accompanied by R.N.A.'s and that they all practise nursing as a team. (Team nursing will be discussed below in the context of analysis of decision-making processes in nursing.)

The areas of general agreement detected in the published statements of nurses' association spokesmen represent a considerable advance over earlier days, when even this degree of consensus was absent. Even so, it seems that the profession still has not resolved the major identity dilemma with which it has been plagued since World War II: does the direction of professional nursing lie in a return to the bedside and an emphasis on the unique nursing function of providing care; or does it lie in the alternative directions of acquiring, for some, assistant doctor status (with a concentration on cure functions) and, for others, a role as general manager and consultant in the area where patients are kept?

Why does this dilemma between bedside care specialist vs. semi-doctor-administrator still exist among nursing leaders? The reason is the status dimension, with its correlates of power, influence and independence, which is a part of all known professional and semi-professional occupations. Nurses accurately perceive that

¹⁶See the Brief of the Registered Nurses' Association of Ontario to the Committee on the Healing Arts, December 1966.

their outstanding contribution to health has been the provision of care; few others will shoulder the burden, and none can carry it as effectively. Yet society has not accorded status to those who "just give care". Admiration, affection, even devotion are lavished on the care giver, but not deference (which is the essence of status) and certainly not power, privilege and influence. These latter rewards society willingly accords to doctors who control *cure* (that is, life and death) and, to a lesser extent, to those laymen who are administrators and thereby control money and make broad policy decisions affecting whole organizations (not just single individuals like patients).

The pathetic aspect of this dilemma is that it is one of the profession's own making. By wanting status (acquired by going into administration and cure activities) yet humanely recognizing the importance of care, they have polarized their activities in irreconcilable alternative directions. In fact, this need not be so at all.

The nurse is truly unique simply because she is the one and only person who can and will attend the patient on a continuous basis. To do this, she must be willing to perform, in part, the role of almost every other health occupational group, as well as be the care specialist. Only in settings where patients do not need continuous attention can she concentrate on being solely a care specialist. But where attention is continuously needed, the nurse's role becomes that of the sole provider of "coordinated continuity" in effecting cure and rehabilitation of the sick person.¹⁷ Some of this coordinated continuity is provided through the nurse incorporating the therapeutic activities within herself so that she is a bit of a physician, a bit of a dietician, a bit of a physiotherapist and social worker, as well as the primary care giver. She must be all these things partly because it is uneconomical to provide round-the-clock attention from these many and varied other personnel, and partly because nursing research itself has shown how detrimental it is to patients to be attended by many different people coming and going at all hours of the day. The remainder of the coordinated continuity provided by the nurse lies in her potential for coordinating the coming and going of those who visit the patient and providing information about the patient to all who are involved in curing him. Conversely, she is the person who can best interpret the actions of these other personnel to the patient, since she is there and knows who is doing what, where and when.

We warn that the above comments are not to be taken to mean an advocacy of the nurse as a convenient dumping ground for all the activities which other occupational groups have neither the time to do nor the interest in doing. The nurse must have considerable formal power in arriving at decisions as to what she

¹⁷The definition of the uniqueness of nursing is discussed in Hans G. Mauksch, "The Organizational Context of Nursing Practice", in Fred Davis, *op. cit.*, pp. 109-137.

will do. Given *equal* power in decision-making (and concomitant recognition and status), the nurse's role will then be determined by the exigencies of the specific situation.

In public health situations, for example, perhaps the nurse can concentrate on being a care and hygiene specialist. In hospitals, the role of the nurse will vary according to the patient's type of illness and condition, and the availability and training of all occupational groups concerned with the case. The point is that the nursing group must have equal power with all the other groups and individuals, including physicians, in formulating the decisions on the responsibilities of each group for each type of patient. We would have, then, a condition of flexible, situationally determined roles formulated by means of frequent, required meetings of representatives of equally powerful and prestigious occupational groups. As will be seen in the discussion of decision-making below, this in fact is the way the nurse's role is defined in a few hospitals today. Significantly, directors of nursing in these situations are not seriously concerned about the dilemma of what a nurse should do. For these nursing officials, the problem is simply one of time allocation. They recognize a primary responsibility for providing care, but beyond that they are willing to accept other responsibilities for their nurses provided their staff is sufficient and well trained. Conversely, they seek to pass on to non-nurses clerical, housekeeping, messenger, dietary and other duties which quite clearly do not involve nursing skills.

Views of Spokesmen for Employing Agencies

The position of the heads of hospitals as revealed through the public pronouncements of association officials is that there are not enough nurses of all types, and that the reason for this is not so much inefficient utilization of existing personnel as an inadequate supply of graduates from the various training programs. They believe that professional nurse spokesmen are more concerned with the profession's status than with providing adequate service. They do not publicly emphasize the need to remove non-nursing activities from nursing; they are against the abolition of R.N.A.'s under any circumstances; they are not convinced that all nursing administrators should have university degrees; and they do not particularly encourage greater emphasis on psychological care. Naturally a number of individual hospital administrators differ to a greater or lesser extent from the public position of their association depicted above. Moreover, while one may say that employer associations fail to emphasize certain ideas and suggestions such as reduction of non-nursing activities, this does not necessarily mean that they would oppose efforts to implement these ideas should they be initiated by others. Rather, they do not consider these matters to be greatly significant to their major concern, the supply of nursing personnel.

Perhaps because nurse employing agencies other than hospitals are not well organized, or perhaps because more ex-nurses obtain positions of executive

authority within them, they are notably less antagonistic to the views of professional nurses' associations. Both the non-hospital employers and the nurses' associations believe there is a need for more public health trained nurses. Employers also are as concerned as nursing spokesmen over the proper role of specially trained and basic R.N. trained nurses.

Views of the Medical Profession

The major concern of the spokesmen of associations of physicians is that the nurse be available to participate more fully in cure activities. Their feeling is that the nursing profession has not been keeping up with the immense advances in diagnostic and therapeutic knowledge and procedures since the Second World War and, as a result, nurses are less able to assist the physician than in the past. Basically, they would like to see much more emphasis on, and training in, clinical specialization than is now the case, with the result that more nurses would be better prepared to do more diagnostic and therapeutic procedures than at present. This view is clearly opposite to that prevalent in the nursing profession, that the uniqueness of nursing is its provision of bedside care and that the profession should therefore resist all attempts to have nurses perform more direct cure activities.

Aside from this divergence of opinion, however, it appears that medical association spokesmen support the views of the professional nurses on most other matters concerning practice, such as the need for getting rid of non-nursing activities and having nurses treated as equal partners on the medical team.¹⁸ Again, it should be pointed out that not all physicians support their association's position. According to many nurses interviewed, a number of doctors still view the nurse very much in the "handmaiden" role, with no particular contribution to make other than doing what she is told and providing basic physical care for their patients. The consequences of such a situation are discussed elsewhere in this report.

Decision-Making Structure and Process

The vast majority of decisions regarding the who, what, when, where and how of nursing practice are made within the employing agencies. Though efforts are made to influence these decisions by individuals and groups outside a particular agency, the actual choices are made by administrators, boards of trustees, medical staff committees, nursing service directors, supervisors, head nurses, individual physicians and non-supervisory staff nurses themselves. The exact role of these decision-makers and the factors which seem to influence their decisions are discussed below under the headings of the specific decision issues which we feel are the most critical to nursing practice.

¹⁸See Ontario Medical Association, *Report of the Special Committee on Nursing* (mimeographed), May 1966.

Decision-Making in Hospitals

Treatment of Individual Patients

The specific nursing needs of each patient are unique to that person. What will be done to him and for him by nurses is decided by the patient's doctor, or individual members of the hospital medical staff; by the head nurse of the nursing unit (or ward) in which the patient is located; and by the staff nurses attending him. Of course the patient himself, if his condition permits, can call for services he feels he needs. Typically, the attending physician specifies what care activities should be performed on the patient (medications, dressings, oxygen therapy, and so on). Physicians vary in the extent to which they specify care activities, but the tendency is to indicate which aspects of routine care should *not* be performed — such as restrictions on moving or positioning the patient. Head nurses record the physicians' orders, and in some cases then specify and schedule the particular care activities for the patient (such as feeding, bathing, positioning, dressings, and so on). Occasionally the details of care are left to team leaders and their teams to work out jointly. (Nursing teams are small groups of staff nurses usually comprising one or two R.N.'s and one or two R.N.A.'s.) In other cases experienced R.N. staff nurses are given charge of a group of patients and are individually responsible for planning their care.

The most commonly reported problems in the decisions about treatment have to do with attending physicians giving unclear orders, inadequate orders, too many orders, or contradictory orders. Sometimes resident medical staff contradict orders by visiting physicians and vice versa. The greatest dilemma occurs when individual physicians order nurses to perform procedures which they are prohibited from doing by hospital policy or for which they have inadequate preparation. While nurses have full authority to refuse to follow such orders, they may feel pressured into doing so because of the emergency nature of the case or the unavailability of authorized and prepared personnel.

Allocation of Nursing Staff

The head nurse is the key figure in deciding how to deploy the staff of a nursing unit, once she knows how many of each type of nurse will be in her unit and how much of what kind of nursing is required by her patients. As a rule most head nurses assign the most complex and difficult nursing activities to the most senior and skilled members of staff, and so on down the line, until the most simple and routine care goes to the least proficient R.N.A. or aide. Within these general guidelines, however, there are three basic patterns for allocation of patients among nursing staff.

The traditional pattern is that one nurse is assigned to a specific number of patients (eight to ten on average) for whom she provides all nursing care. This system was feasible in the days before the registered nursing assistant, but it is not operable in its pure form today. The present modification of the system is to

assign a patient to an R.N. or R.N.A., depending on the complexity of his nursing needs. Patients requiring the most routine care are given to R.N.A.'s; however, since even the least sick hospital patients usually require some treatments which only R.N.'s may give (such as medications), R.N.'s must occasionally leave "their" patients to do special procedures for R.N.A.'s patients. This system works fairly well as long as the R.N.A.'s patients do not require many "R.N. only" treatments. Otherwise the R.N.'s become overworked.

The second common allocation model is the functional approach by which specific nursing procedures are performed on a unit-wide assembly line basis. Nurses do not get specific patients assigned to them so much as specific functions. R.N.'s typically do the medications, irrigations and other "R.N. only" tasks for all patients requiring them, while R.N.A.'s give baths, back rubs, clean-ups, and so on. For procedures which all patients must receive at designated times of day, such as feeding, all staff usually turn to and sweep down the ward getting them done quickly and efficiently.

The main problem with this system is its exceptional impersonality, especially on large units. Patients never get the feeling of "their nurse" knowing them and looking after them. A third and increasingly popular system, which tries to escape the over-burdened R.N. problem of the traditional approach and the impersonality of the functional approach, is the team nursing system. In its ideal form a team of anywhere from three to five R.N.'s and R.N.A.'s plans and gives care to a designated group of patients (usually between fifteen and thirty). An R.N. is appointed as team leader. She conducts team conferences in which the whole team participates in developing the nursing plan for each patient; she also oversees the allocation of patients and tasks among all team members. While specific patients may be allocated to specific team members, all team members help each other as needed. The patient comes to recognize and feel confidence in his or her team.

We visited several hospitals where team nursing was being practised, but in none of them was the system working perfectly in all units. The usual difficulty was that the team members were not given any responsibility for planning care or allocating their own resources. This was often because the head nurse was unwilling to relinquish these responsibilities. There were also problems in getting team members to help one another and in establishing the authority of the team leader. Additional difficulties arose in developing continuity of teams because of having to accommodate part-time staff and varied day-off schedules. It was felt by nursing directors that most of these problems could be eliminated with better planning techniques and proper in-service training for head nurses, who in turn would train their staff in the proper use of the system.

Though the head nurse of a unit is the official locus of decisions regarding the allocation of staff to patients, her actions in this matter are, in fact, constrained

by a number of factors over which she has no direct control. These are the basic determinants of who will do what:

- 1) The general nursing department policies regarding permitted and prohibited procedures, especially for R.N.A.'s and non-registered diploma graduates.
- 2) The degree of matching between the size of the unit and amount and complexity of nursing care required on the one hand and the number, type and proficiency of staff on the other. Mismatching leads to R.N.'s being overburdened or underutilized, or to R.N.A.'s and other aides having to do procedures for which they are inadequately prepared. An excessively high proportion of inexperienced or otherwise unproficient staff puts undue burdens on the remainder. Description of how the crucial decisions about total staff size and composition are made will be found in Chapter 4 on "Nursing Supply and Demand".
- 3) A high proportion of non-bedside activities required of staff similarly affects the amount of time nurses can spend with patients and the quality of their ministrations.

In spite of the fact that the head nurse's decisions on how to use her staff are strongly influenced by policy matters beyond her control, she still seems to have a great deal of veto power in the application of these policies to the running of her unit. In a number of hospitals visited, directors of nursing service and nursing supervisors (the level between director and head nurse) commented on the difficulties they had in persuading their head nurses to do such things as adopt team nursing; make better use of ward clerks, nurse's aides and housekeepers; and allow R.N.A.'s to perform certain procedures. From the other side, staff nurses frequently complained about unwarranted discrimination on the part of head nurses in favour of some staff members and against others in what they permitted them to do. Though these details of how staff are used at the unit level may seem picayune in the analysis of manpower utilization at the province-wide level, the fact is, if there should prove to be a large number of ineffective or recalcitrant head nurses in nursing units across the province, they might well have a major effect on such broad matters as province-wide nursing turnover, underutilization of resources, and substandard quality of care.

Permitted and Prohibited Cure Procedures for Nurses

The vast majority of cure related procedures for R.N.'s have been long established by tradition and law (though admittedly the law concerning what an R.N. may and may not do is rather vague¹⁹).

¹⁹See B. C. Westlake, *A Comparative Study of Discipline in the Healing Arts Professions*, a study for the Committee on the Healing Arts (mimeo.), July 1967.

Much of this long-established past practice is codified in the procedure manuals to be found in most hospital units. These are drawn up under the direction of the director of nurses and chief of medical staff, usually in consultation with immediate nursing subordinates and sometimes with the advice of head nurses. Practice in consulting subordinates varies from hospital to hospital and depends largely on the degree of authoritarianism of the nursing director and the calibre of her subordinates. The final authority for all medical procedures carried out by nurses, however, lies with the medical advisory committee of the hospital or with some individual or subcommittee designated by it. In no case did we find the director of nursing to be a member of the committee which approves the medical procedures for nurses. Her interests on this committee were represented officially by the hospital administrator, who is a member.

Initiation for changes in current practice usually comes from members of the hospital's medical staff. Occasionally staff nurses or head nurses will initiate requests to their director for a change in procedures, usually as a result of pressure from individual physicians to do them without formal approval. In any case, the medical advisory committee usually consults the director of nursing to establish that she would approve of her staff doing the particular procedure under consideration. We did not encounter any cases where the directors of nursing actually declined to give this permission, although two or three we spoke to felt that physicians generally try to pass too much on to the nurses. The medical advisory committee makes its decision and then informs the director of nursing. Usually the decision is to let certain designated individuals perform the procedure and to specifically train this designated group of nurses in the procedure before they carry it out. The medical advisory committee may then assist also in setting up the necessary in-service training program.

Although the medical advisory committee of each hospital has full and final say regarding which medical procedures will be delegated to R.N.'s, its decisions in turn must be made within general policy on medical practice laid down by the College of Physicians and Surgeons of Ontario. The College of Physicians and Surgeons has put forward a policy on "Special Procedures by Registered Nurses and Technical Personnel", which lays down what medical procedures may be performed by designated non-physicians, and how the medical authorities in hospitals should formulate and regulate their policies on these procedures.²⁰ This is a permissive policy, and it is up to the medical authority of each employing agency to decide which of the fourteen designated special procedures they will allow nurses and technicians to perform. Interestingly enough, the College has only in the past year resolved the problem of approving of the performance of medical procedures by non-members of the College. They have done this by renaming them "special procedures". The dilemma posed by this solution is that, if a "special procedure" is no longer a "medical procedure", then perhaps the

²⁰See *Report of the College of Physicians and Surgeons of Ontario*, July 1967, p. 16.

practice of it is no longer controllable by the College. Although this fine legal point has not been resolved, in fact it causes little trouble in hospitals since, as mentioned, the medical authority has the final say on policy within the organization.

In the case of "special procedures" not covered within the broad policies now laid down by the College (such as the delivery of babies by nurse midwives), the procedure is for the medical authority of the hospital or other agency wishing to permit such practice to submit the question to the College for a decision. The procedure may not be delegated to a nurse until the College has given its approval.

In a nutshell, then, it appears that R.N.'s have at best a veto power in deciding what cure procedures they will engage in; and that, so far as we could tell, it is seldom — if ever — exercised. The one facet of the cure component of the nurse's job which is not controlled by physicians is the subtle and difficult evaluative aspect which gives each nurse responsibility for judging and reporting any serious change in a patient's condition. Ultimately her competence in doing this is determined by the quality of her training, experience and native ability.

Registered nursing assistants have even less influence over the determination of the procedures they will perform than do the R.N.'s. Broad policies for R.N.A.'s are made by the director of nursing, and specific practices are decided by head nurses. These decisions are supposed to be based primarily on knowledge of the R.N.A.'s training curriculum, so that the R.N.A. should be given no more nor less than she is able to do. Unfortunately, however, as a result of temporary or permanent shortages of R.N.'s in a particular hospital or unit, R.N.A.'s are often given procedures (such as doing blood pressures, and administering some medications) for which they are not formally prepared. In most cases only certain R.N.A.'s are allowed to do this, and special training is provided for them. In a few instances, certain experienced R.N.A.'s themselves ask for and receive a broadening of responsibilities. Conversely, there were complaints by both the Ontario Association of Registered Nursing Assistants and a few nursing directors that R.N.A.'s on some units are not permitted to perform even those procedures for which they have been trained, because of mistrust and jealousy by head nurses. The key point regarding R.N.A.'s, however, is that the pattern of utilization is highly variable because the locus of decision is decentralized at least to nursing director level, and often to the unit level within the hospital.

Care Procedures

The same procedure manuals which specify permitted and prohibited cure procedures for R.N.'s and R.N.A.'s also describe the care procedures to be followed in nursing units. In this case, however, their determination rests fully and finally with the director of nursing or a procedures committee set up within the nursing department. Medical and other officials in the hospital can recommend changes in procedure, but the director or the procedures committee makes the final decision.

In most of the hospitals studied, the development and change of procedures involved a great deal of consultation among all levels of the nursing department hierarchy down to the head nurse level. Involvement of the non-supervisory staff in discussing potential care procedure changes was much more variable, ranging from frequent discussions with staff members in teams or on a unit-wide basis, to completely unilateral decisions by the procedures committee.

The most important innovations in care procedures today are greater emphasis on psychological care; the development of specialized knowledge and techniques for major clinical areas; and the development of continuity of care between the hospital and community agencies, nursing homes and the patient's own home.

In the case of increased emphasis on psychological care, we found most of the directors of nursing we interviewed were very sensitive to the need for this, yet were rather discouraged with the possibility of actually implementing change. Many of them felt that a successful program to increase the quantity and quality of this aspect of care would require whole-hearted acceptance and support by the chief medical and administrative authorities in the hospital, plus a large-scale training program for all staff who come in direct contact with patients and a special program for head nurses and physicians — the two main daily influences on the nursing staff. The feeling of discouragement was based on their feeling that the acceptance of the importance of psychological care by administrators and physicians was low, and that the money, time, facilities and teaching staff for a thorough training program would not be available.

We also asked the directors what actual efforts they had made to develop psychological care. Most had done nothing, because they felt that nothing they could do would yield the necessary resources for training. They simply hoped that improvement would come about as their hospital hired more new graduates whose training had included the subject. In three cases the major effort was discussion of this form of care at regular meetings with supervisory staff and urging head nurses to conduct similar meetings with their own staff groups.

The other constraints on increased psychological care, which virtually all nursing directors mentioned, were inadequate numbers of staff, and the fact that current staff had to perform too many non-nursing activities.

The development of specialization in nursing is only partly a problem of nursing practice. It is also a question of training, and as such will be treated in a later chapter. Nevertheless, in the realm of practice, nursing procedures must be developed and evaluated for patients with specific types of illness. In most hospitals visited there was very little official emphasis on specialization; nor was a great deal of interest expressed by nursing department officials at any level. Where

specialized procedures existed, they were developed within the unit on a more or less informal basis and passed on to incoming staff members. Eventually they would be incorporated into the unit's procedure manual.

In none of the hospitals visited were there any formal programs of research, with money or staff specifically designated to carry out studies on nursing procedures. A couple of hospitals mentioned that they had done simple projects when they wanted to demonstrate to physicians or administrators the need for certain changes in equipment, supplies or regulations. Those nursing directors who wished research could be done (usually those in large teaching hospitals) said that none was being done because there were too few qualified people to do it, rather than that there was too little money. One hospital, not yet open, had created several clinical specialist positions in the hope that, through the use of such positions, development of specialized procedures would be a little more systematic, scientific and better communicated.

In the case of decisions concerning after-care or continuity of care for patients following hospitalization, the locus of decision here appears to be joint consultation between hospital officials and heads of various public health and visiting nurse associations. A large and beneficial incentive has been provided by the Ontario Hospital Services Commission's new home-care program, which provides financial coverage of designated patients being cared for at home. Even so, there is still much to be done in providing effective liaison between the hospital and other health agencies. Again, according to our informants, the problem is one of developing a favourable attitude among the chief administrators in both hospitals and the outside agencies, plus creating and staffing specific positions for nurses to plan and carry out continuity programs.

Non-Nursing Activities Performed by Nurses

It has been established that nurses of all types perform activities which are of little direct relevance to the care and cure of patients. In addition, this under-utilization of nursing resources has for years been noted and criticized by spokesmen for the nursing profession. Who determines the amount and kind of activities which we have classified as "clerical" and "logistic" which nurses do, and what forces influence these decisions?

The primary locus of decisions of this kind in Ontario hospitals is the hospital administrator. While he must obtain the official approval of his board of trustees and of the Ontario Hospital Services Commission for actions which involve the expenditure of large amounts of money, we found no evidence that these bodies typically refuse such approval. In the vast majority of cases they accede to the wishes of the administrator, provided that he can justify his proposals. Thus he in fact possesses the effective power to control many key decisions on manpower resources in the hospital.

Decisions concerning performance of clerical and logistic tasks by nurses are not, in turn, delegated to the director of nursing because, in most cases, they involve the functions performed by other departments; the creation of new positions or even new job classifications; and often innovation in layout, equipment and basic systems for the allocation of patients to units. Such matters of interdepartmental coordination, broad policy formulation, and major budget expenditure clearly lie beyond the role of the director of nursing, no matter how broadly the position is defined.

The kind of things which *can* be done in hospital to create more time for nurses to spend in direct care and cure activities are revealed in the pages of various journals of nursing and hospital administration, as well as in one newly designed hospital which was yet to be opened when we visited it. It is reliably estimated by one hospital consultant that if all of the below noted changes were made, a minimum of 30 per cent of the nurses' time could be saved.²¹ The significance of this for alleviating nursing shortages and increasing the quality of care is obvious.

One set of changes to improve nursing resource utilization involves the reallocation to other departments and functional groups of tasks presently performed by nurses. In particular, the duties of housekeeping and ward aide staff could be broadened in some cases; members of the food services department could be made responsible for distributing meals directly to patients rather than just to nursing stations; members of pharmacy, rehabilitation and other hospital groups upon whom patients depend could provide their services in evening shifts and on weekends and holidays, rather than have nurses doing part of their work at these times.

Other activities performed by nurses can be allocated to entirely new positions. Many hospitals have failed to make good use of ward clerks to handle telephone calls, to direct visitors, and to perform much of the paper work. This is partly because suitable people cannot be hired at current rates, partly because the clerks are not well trained, and partly because head nurses are reluctant to use them as much as they might. Even so, where they were used in the hospitals we visited, they were much appreciated by nursing staff. We noticed, however, that there were many units and whole hospitals where the ward clerk position had not yet been introduced.

There is a certain amount of enthusiasm in the United States for the position of ward manager — a non-nurse representative of hospital administration who is based in the wards and is responsible for planning, organizing, directing, co-

²¹"Friesen's 'production-line' concept gaining ground", *Hospital Administration in Canada*, Vol. 9, No. 1, January 1967.

ordinating and controlling all non-nursing staff and non-nursing functions on the ward. The position of head nurse in this system involves solely the planning and supervision of the trained nursing staff.

The model for this system is the University of Florida teaching hospital in Gainesville.²² Though it has apparently worked well in this hospital and in one or two others where it has been tried, one suspects that a good deal of success is due to a particularly congenial climate of interpersonal relations brought about through the use of specially selected personnel, above average in training and human relations skills (for example, at Gainesville nursing unit directors are also members of the university nursing school faculty). Certainly current theory on organization and administration suggests that functions which are as interdependent as those performed by nursing and non-nursing staff in a hospital unit should have a common superior. With two independent superiors overseeing interdependent activities, the potential for disruptive conflict and lack of coordination is much greater.

Another new non-nursing position which could be of great value is that of supply officer. This is a person trained in the preparation and distribution of all types of supplies other than food and drugs. This position is usually part of a centralized supply department, which prepares supplies for each nursing unit in a central location and distributes them to the units, or, where possible, to the patients' rooms. The unit supply officer looks after preparation of supply requisitions, distribution of supplies within the unit, pick-up of used supplies, and obtaining emergency supplies as needed.

The services of messengers and porters are similarly inadequate or improperly used in many hospitals, with the result that R.N.'s and R.N.A.'s do more errand running than they should. Part of this can be overcome by improved distribution and communication equipment, and part by more systematic utilization planning and better training of auxiliary personnel.

The reallocation to other personnel of certain tasks done by nurses is only part of the answer to more effective nurse resource utilization. Most of the hospitals visited had done at least some of this reallocation, but the vast majority could do much more. Reallocation efforts are usually less than perfectly successful, however, unless there is an accompanying redesign of the systems of information flow, communication and distribution.

In a majority of the hospitals visited nurses constantly complained of too much paper work. In part, this problem may be solved by proper use of ward

²²See Lucille T. Mercandante, "An Organizational Plan for Nursing Service", *Nursing Outlook*, Vol. 9, No. 5, May 1962.

clerks, but it can be mitigated also by redesign of the systems of records and reports to eliminate needless copying of doctors' orders and unnecessary nurses' notes, and to simplify the multitude of other forms required in the hospital.

Time spent by nurses in trying to locate supervisory, medical or other personnel can be reduced by the use of improved intra-hospital telephone or PA systems, and "page-boy" or other types of short-range radio devices. Various forms of centralized supply and automatic distribution systems similarly reduce the searching, fetching and carrying activities of nurses.

Beyond the redesign of information, communication and distribution systems, even more widespread changes can be made to improve the utilization of nursing staff. Leading hospital architects have shown that the layout of the nursing units in terms of size, number of beds, position of nursing stations, and design of patient rooms can lead to greater efficiency.

Of equal significance, however, is the method of allocating patients to units. The present basis for the formation of units in most hospitals is a medical one, and patients are allocated according to their medical diagnosis. Thus, for example, we have medical, surgical, obstetrical, gynaecological and psychiatric wards. As a result, in many wards, the type of nursing care required in a given unit is highly variable, both at any point in time and over a period of time. Some individuals in a unit require only the most routine kind of care, whereas others require highly complex care, both physically and psychologically. Since the mix of patients varies unpredictably over time in terms of nursing care required, the head nurse is frequently in the position of either underutilizing the skills of her R.N.'s or requiring her R.N.A.'s to perform procedures for which they are poorly prepared.

Kovner has recently advanced the idea of organizing nursing units on the basis of nursing care required.²³ Such a system would mean that those patients requiring routine care only, those requiring moderately routine care, and those requiring complex nursing care would be grouped separately and assigned to separate units. This assignment to units on the basis of a *nursing* diagnosis rather than a medical diagnosis would permit an infinitely more efficient basis for planning the necessary mix of R.N.'s and R.N.A.'s, and for maximizing the utilization of skills of each type of nurse.

The existing system which comes closest to that advocated by Kovner is known as Progressive Patient Care (PPC). By this system the hospital provides units for ambulatory "self-care" patients; "intermediate" patients requiring a

²³See Anthony R. Kovner, *The Nursing Unit: A Technological Perspective*, unpublished Ph.D. thesis, University of Pittsburgh, 1966.

moderate amount of care; and "intensive care" patients requiring maximum attention and care. This system has not been widely adopted and where it has, it has been in smaller hospitals in the 200-300 bed range.²⁴

Given that the great majority of the above techniques for reducing the non-nursing activities of nurses and matching work assignments to training and ability have been tried and proven in a number of individual hospitals (mainly in the United States), the crucial question is why they have not been implemented on a wide scale in Ontario hospitals.

The obvious answers are inertia and inadequate cost-benefit analysis. The decision-makers often seem to be aware of most of the techniques; but they consider the great amount of planning, preparation and surveillance necessary to try them in their particular hospital to be too much. Since inertia is a socially unacceptable response to challenges to innovation, however, the conventional replies are, "it costs too much", "it wouldn't be worth it", or "it wouldn't work in this hospital". All these responses reflect an inadequate analysis of the costs involved and the benefits to be obtained. Some cost-benefit analyses carried out by administrators are inadequate, because the data on costs are exaggerated. But most are inaccurate because not all the benefits are considered; because the amount of benefits is difficult to predict; and because, since monetary equivalents of some benefits are not or cannot be estimated, the excess of cost over benefit, interpreted solely in money terms, invariably seems to be too great.

Why does this inertia exist, and why are cost-benefit analyses inadequate? To answer these questions, we have to understand the detailed nature of the decision-making process in hospitals.²⁵ Although the administrator is the effective decision-maker on most of the questions of change raised above, he does not make his decisions in a vacuum. In particular, much of the defining of problems, searching for solutions, and evaluating of solutions is performed by various high level committees and subcommittees made up of department or section heads and medical staff. Even outside the hospital's committee structure, individual senior officials can exert disproportionate influence on the administrator, either because they possess forceful personalities or because they are leaders of exclusive and highly essential (to the hospital) groups which can speak as one mind (such as resident physicians, certain laboratory departments). Unfortunately we found all too often that the directors of nursing, though highly capable, were not forceful personalities. Nor did they have a large amount of power in the organization since, though the nursing service is essential, it is hardly a small, exclusive group

²⁴See Lewis E. Weeks and J. R. Griffith (eds.), *Progressive Patient Care: An Anthology*, University of Michigan, Ann Arbor, 1964.

²⁵For a recent review of research and theory on this subject, see Charles Perrow, "Hospitals: Technology, Structure and Goals" in James G. March (ed.), *Handbook of Organizations*, Rand McNally, Chicago, 1965, pp. 910-971.

in which the staff can know each other's ideas and opinions and come to think and act in a united way vis-à-vis the administrator or other members of major policy-recommending committees.

Thus we found that most nursing directors were unwilling to press forcefully for large-scale reallocations of functions, creation of new positions, changes in systems of distribution or communication, or innovations in layout or patient allocation systems. Most innovative efforts we did hear about were of the type involving the reallocation of activities performed by nurses to departments of lower status than themselves (in the informal status hierarchy of the hospital), such as housekeeping and dietary departments. Even in these instances, the efforts were not always successful due to a general reluctance on the part of members from other departments on the key committees to have nursing shift any of its duties to anyone.

Another major reason that high level committee members and administrators fail to initiate and wholeheartedly support large-scale efforts to improve the utilization of nursing staff is that detailed advice and guidance in such matters is not provided by the Ontario Hospital Services Commission. The Commission is, on the whole, very permissive with hospitals, allowing each of them wide latitude in deciding how the hospital will be run. Minimum standards are laid down and enforced in a very low pressure fashion: consultants provided by the Commission for each of the major hospital functions check to ascertain that these standards are being met within the functional areas they represent; to a much lesser extent they attempt to provide advice and information on improving standards to the heads of their functional specialties within hospitals. But never does a *team* of OHSC consultants visit a hospital to perform an integrated study of ways in which the hospital can improve. This can be explained largely by the shortage of good consultants, but also partly by a lack of integrated planning and research among the consultant groups within the OHSC head office. In many ways the consultant groups within OHSC are as divided and mutually suspicious of each other as their counterparts in the hospitals they visit.

Finally, we must not overlook the influence of the major extra-hospital interest groups on the key decision-makers within the hospital: the Ontario Hospital Association, the Registered Nurses' Association of Ontario, and the Ontario Medical Association. While all of these bodies stoutly maintain that better use could and should be made of the hospital's nursing resources, they seem to have devoted little in the way of time, money or personnel to researching and developing specific plans for introducing improvements in this area. At best they are willing to run articles on the subject in their various publications, but when it comes to making public pronouncements about what matters to them most, the main interest of the OHA appears to be getting more staff; the RNAO is concerned

primarily with wages, hours, working conditions and educational issues; and the OMA simply hopes that nurses and doctors can work more closely and that nurses can provide more help in the cure procedure area.

In all fairness, it should be noted that the OHA and the RNAO sponsor, both separately and together, a variety of workshops and institutes, some of which deal with the improved utilization of nursing resources. These draw mainly nursing administrators and teachers and, as such, are probably helpful in encouraging changes in procedures and systems within nursing units. Since really significant improvement requires the support and approval of hospital administrators and physicians, as well as that of the heads of major related departments, however, programs for nurses only probably will not yield large-scale benefits. In 1967 one program was run involving thirty-six pairs of nursing directors and hospital administrators from the same hospital. This is a small but noteworthy beginning. Meanwhile there is no continuous formal cooperation among the full-time experts in the OHA and the RNAO for the purpose of working out and testing detailed programs of change in nursing practice.

Decision-Making in Non-Hospital Settings

Although the greatest proportion of our field research on the decision-making structure and process in nursing was spent in investigating hospitals, we did observe the situation in other settings in which nurses are employed.

The maximum control by nurses over the activities of various classes of non-supervisory nursing personnel was found in the *visiting nurse agencies*. Practically all the persons in authority in these organizations are themselves registered nurses, usually with a university degree. The sole function of these organizations is to provide nursing care, and there are no competing functional departments or non-nursing administrators to contend with. Only in the case of the establishment of permissible cure procedures for the visiting nurses is there a need to appeal to non-nurses in the form of medical advisory committees. The largest visiting nurse organization, the Victorian Order of Nurses, faces one major problem in its decision-making structure. Because the organization is extremely decentralized, each region decides for itself what standards and procedures of care to adopt; this situation creates difficulties when the Order tries to persuade the regions to at least try innovations which have enhanced nursing effectiveness elsewhere.

Government public health agencies also have some advantage over hospitals in that the work done by the nurse seems to be more clearly delimited and independent. She has little in the way of cure procedures to perform, and her clerical and logistic or non-nursing activities are less. Public health nurses must coordinate and integrate some of their work with other occupational groups in the agency; but we got the impression that this coordination comes more easily because the nursing group is closer in power and status to the others and the atmosphere of mutual respect for each other's contribution is greater. No doubt

it helps that fewer physicians are involved in agencies, and those that do participate in the decision process are full-time career public health physicians representing only a few other similar physicians.

The most important current decision issue in both the governmental and visiting nurse agencies is the role of the non-public health specialist R.N. and the R.N.A. The pressure for expanding the use of these non-specialists comes from the increasing discrepancy between the demand for and the supply of specialists. Here the debate is primarily among nursing officials, with some hoping to ease the shortage solely through education of more specialists and others willing to expand the uses of non-public health certificate nurses. Since there is relatively little pressure for immediate results from large and powerful lobby groups like the Ontario Hospital Association and since, so far at least, the non-nursing administrators of government agencies have not made loud *public* outcries about the shortage, the investigation of how to expand the use of the non-public health specialists and how to better utilize the specialists is moving slowly.

In the case of nursing for *independent employers* (industry, nursing homes, doctors' clinics, and so on), and *private duty nursing*, there is very little pattern to the process of deciding what the nurse will do. It ranges from almost total autonomy for the individual nurse (in some private duty nursing and in certain businesses, for example) to very strict delimitation and control of non-nurses (as in some doctors' clinics).

In the case of private duty nursing, the registry which assigns nurses to cases has a very general control over what the nurse will do, in that the registry is told — or has to judge — whether the case requires an R.N., an R.N.A. or a non-registered "nurse". This allocation decision is influenced mainly by the recommendation of the attending physician on the case, but it is also tempered by the availability of nurses and the desire on the part of commercial registries not to lose business.

The problem of governing the standards used by nursing registries in allocating and supervising the private duty care given by employees of nursing registries has been given to the Ontario College of Nurses (under Section 10 (e) of the Nurses' Act). To date the College has not come up with a set of regulations, partly because of lack of time and partly because it has been unable to devise enforceable standards by which the registries' practices can be judged. Although the College hopes to produce its regulations soon, the problem remains, if the aim is to control the actual quality of care provided by the private duty nurse. The kind of nursing required depends on how sick the patient is, but as yet no one is willing or able to specify legally who may or may not perform each of the hundreds of nursing procedures and techniques. Hence, to know the condition of a patient does not permit one to state with certainty that only an R.N. with specialized training, or a general R.N., or an R.N.A., or a non-registered person would be suitable to nurse that patient.

The situation in *nursing homes* is rather a complex one. There are three main types of nursing homes: "Homes for the Aged", regulated by the Homes for the Aged Act and financed by provincial and municipal funds; "Charitable Institutions", regulated by the Charitable Institutions Act and 80 per cent financed by provincial funds; and all other nursing homes — privately operated homes which, until 1967, were regulated by municipal or county health authorities and financed by a variety of means, depending on the patient's income and whatever welfare agency (if any) the patient came under. In 1966 the province passed "An Act to Provide for the Licensing and Regulation of Nursing Homes", and in 1967 the regulations governing the Act were produced and came into effect.

None of the regulating bodies or laws governing the three types of nursing homes specifies in any detail what nurses must or must not do; however, they do state the minimum number of each type of nursing staff which should be *present*. The regulations are so devised that the vast majority of R.N.'s are solely in administrative positions (for example, in nursing homes there must be at least one registered nurse on duty twelve hours per week and on call at all times). Insofar as a nursing home adheres only to the minimum requirement, R.N.A.'s similarly are primarily in supervisory positions. In nursing homes there must be one R.N.A. on duty twenty-four hours per week, regardless of the number and condition of patients. The great bulk of nursing care, therefore, is given by non-registered nursing help who may or may not have formal training. The quantity and quality of nursing care in various types of nursing homes is thus highly variable, depending on the policies and financial condition of each home. It appears that government regulations having to do with the number and type of nursing staff in nursing homes would be much more sound were they based on the size of each institution and, particularly, on the amount and complexity of nursing care required on average. It appears also that more attention must be paid to the financing of private nursing homes in order to permit the implementation of higher standards of care.²⁶

Summary

This chapter has dealt solely with the actual tasks of nursing. Subsequent chapters will discuss the context in which the tasks are performed (wages, hours and working conditions), the demand for and supply of people to perform them, the qualifications necessary to perform them, and the education required. This section concludes, therefore, with a recapitulation of the problems of nursing practice and a discussion of some of their major determinants.

The Problems

Whether or not the current state of nursing practice is seen as inadequate in any way depends very much on one's basic assumption about the nature of nursing

²⁶See "Nursing Homes — To Be or Not To Be", *RNAO News*, Vol. 23, No. 5, November-December 1967, pp. 2-6.

and how the various classes of nurse should be spending their time. We have assumed that the essence of nursing is the direct application of skill, knowledge and judgement to the provision of physical and psychological comfort for the sick; aiding the physician in effecting cure; and aiding the patient in re-establishing and maintaining his own health. Ideally, all nurses should spend all their time ministering to the needs of their patients. Indirect activities which permit the direct activities to be engaged in should be performed by non-nurses — with the exception of teaching, research and nursing administration. Who should perform which of the direct activities should be determined on the basis of the condition of the patient and the ability of the nurse (as determined by training, experience and aptitude). Patients in serious condition and whose reaction to treatment is unpredictable will require nursing care which demands high skill in the application of both physical and psychological procedures, considerable medical knowledge, exceptional judgement, and an ability to communicate and cooperate with other members of the medical team. At the other extreme, patients with minor health problems and whose reaction to treatment is highly predictable will require nursing care which is routine and not difficult to carry out, minimal amounts of medical knowledge and judgement, and minimal communication and coordination with others. To the extent that nurses perform indirect activities or direct activities for which they are inadequately prepared, or fail to perform those direct activities for which they are prepared, there is a misuse of resources.

With these assumptions in mind, we can state the following to be the major problems of nursing practice today:

- 1) Too many nurses of all types (R.N.'s and R.N.A.'s) are having to do too many non-nursing activities.
- 2) There is not enough attention paid to the provision of psychological care (that is, trying to discover and alleviate the emotional discomfort created in the patient as a result of the state of his health).
- 3) Registered nurses are too often put in the position where their contribution to patient comfort or aid to the physician is less than optimum due to inadequate skill and knowledge.
- 4) Registered nurses and, to a lesser extent, registered nursing assistants too often spend too much time doing nursing activities which underutilize their nursing skill and knowledge.
- 5) Similarly, registered nursing assistants are too often required to perform nursing procedures for which they are inadequately prepared.
- 6) Orderlies are males who perform simple direct nursing functions; however, their role as nurses is very poorly defined. As a result, they are either inadequately trained or they are used mainly as medical janitors and messengers.

- 7) The need for continuity and change in the nursing needs of patients is inadequately recognized. As the patient moves from illness to recovery, there is failure to recognize his changing nursing needs, especially in the transition into and out of hospital or from one health agency to another.
- 8) In the realm of public health nursing, there is a failure to discriminate the complexity of nursing requirements; as a result, the roles of the non-public health specialist R.N. and the R.N.A. are inadequately defined.
- 9) In the ideal world it would be desirable to ensure that no one was pressured or permitted to perform any procedure on, or give any assistance to, a person unless he or she was properly qualified to give it.

Since nurses are the best, and perhaps the only, people able to judge whether or not a person is qualified to practise nursing activities, nurses should assign and oversee nursing practice.

Reasons for the Problems

As mentioned, the problems of nursing practice are affected by, and in turn affect, problems of supply and demand, working conditions and education. Aside from this, however, the nature of practice is influenced quite directly by certain other conditions:

- 1) The position of nursing in the decision-making structure of the hospital is weak, and the quality of interdepartmental coordination and cooperation is poor. As a result there is inadequate appreciation of the need for shifting non-nursing activities away from the trained nurse and a reluctance to plan and implement programs to create new positions, change old job descriptions, and work out new systems for coordinating interdependent positions.
- 2) There is not enough specialized training for nursing patients with complex types of nursing problems.
- 3) There is not enough basic research into the means for diagnosing nursing needs and into the effectiveness of nursing procedures.
- 4) Physicians fail to treat the nurse as a thinking partner on the health team. They communicate inadequately with her and discourage communication from her.
- 5) Inadequate attention is paid to developing means for grouping patients according to the severity of their illness in nursing terms. This leads to overstaffing or understaffing, and sub-optimum mixes of R.N.'s and R.N.A.'s.
- 6) Too many nursing administrators lack the knowledge or motivation

to develop intra-unit techniques for better utilizing their staff. Others have the knowledge but not the time or the power to institute the desired changes.

- 7) Pressure and aid from the Ontario Hospital Services Commission in the area of more effective utilization of nursing resources have been too little. There have been too few consultants, and they have not been able to coordinate their activities with other consultants or other functions vis-à-vis specific hospitals. As a result the direct pressure for change in hospitals is low, and integrated studies of hospital operations which would provide guidance cannot now be carried out.
- 8) Non-nursing bodies with an interest in nursing exert the wrong kind of pressure. The Ontario Hospital Association pushes mainly for a larger supply of nurses; the Ontario Medical Association exerts little pressure at all on its members with regard to nurses, and that which it does exert has mainly to do with expanding their utility in providing cure activities, while overlooking the development of better care.
- 9) The nursing profession itself is in a state of considerable conflict and uncertainty over its goals, what should be done about them, and the relative priorities of various goals and programs. All this uses up immense amounts of energy and slows progress on all fronts. Thus we have the picture of R.N.'s disagreeing with R.N.A.'s over the role of the latter; of R.N. diploma graduates differing with R.N. degree graduates over the value of the degree and its significance as a requirement in administration and other functions. We see "educationists" in the schools and universities contending with service-oriented nurses over how much and what kind of education is best. And, finally, those who are dedicated to a lifelong career in nursing are trying to change the outlook of those who see it only as an interesting job which one does before marriage, or as a means of making extra money and relieving boredom after marriage.

Most of these internal conflicts are about relatively abstract issues. They seldom refer directly to the patient and what specifically he needs in the way of nursing care and its proper coordination with other aspects of treatment. While the vast majority of nurses wish to have more time at the bedside, they will not get vital cooperation and support from powerful doctors and administrators until they can state with greater clarity and more unity what exactly they should do there for the person in the bed.

- 10) The approach to the control of nursing activities in private practice, nursing homes and other casual employment bases of nurses which is preferred by professional nursing associations is that of changing the basis of qualification from simple registration to a system of licensure of all those who nurse for hire; this would prohibit all non-licensed persons from using the word "nurse" to describe their occupation. Though a system of licensure has been instituted in several Canadian provinces and American states, it apparently has been unsuccessful in confining the use of the word "nurse" to only those who are licensed. The problem is that it is simply not possible, as yet, to specify those activities which should be performed *only* by registered nurses. Thus, a system of licensure would not ensure that unlicensed nurses would be prohibited from doing things for which they are not qualified.

Even if it *were* possible to delimit those activities which were uniquely nursing activities and hence could be done only by licensed nurses, it is difficult to see how it would be economically or physically possible to provide an adequate check on nursing activities carried out in private homes, industrial organizations or nursing homes, where a qualified nurse is not present at all times to act in a supervisory capacity. Since vast amounts of the activity carried out in such places obviously do *not* require full nursing training (making beds, bathing, feeding, rubbing backs, and so on), one cannot realistically legislate that all care of the sick should be performed by qualified nurses.

In the end it appears that the most one can do is, first, try to ensure that some kind of supervision is exerted by qualified nurses wherever the degree of illness warrants it; and second, mount a massive public education program in an attempt to make the public aware of the differences in qualifications of registered as opposed to non-registered nurses, and the differences in the type and quality of care provided by the two.

- 11) A solution offered by the Registered Nurses' Association of Ontario to the problem of R.N.A.'s doing work for which they are not qualified is to abolish the R.N.A. classification altogether by absorbing it into the R.N. This would be done slowly and only insofar as the quantity of nursing service were not reduced. Quite aside from the fact that the elimination of this category of nurse would be an immensely costly and prolonged business, it is our feeling that the assumptions on which the idea is based are not valid. What is being said, in effect, is that it is possible to categorize nursing activities into only two discrete classes — "technical" activities, and "professional" activities; and that a basic R.N.

qualification will be sufficient to perform all technical activities and a B.Sc.N., R.N. qualification will be sufficient to perform the rest.

The trouble is that there is no *a priori* basis for saying that nursing activities can be dichotomized. That the profession itself recognizes this is reflected in the growing pressure for specialized registers *within* the R.N. class and the creation of special programs to provide competence in certain complex nursing areas. This, of course, would create *more* differentiations in the nursing ranks — a result which is quite inconsistent with the aim of collapsing the number of ranks by doing away with R.N.A.'s.

It would be much more appealing to see the organized nursing profession working assiduously at: 1) the basic research necessary to establish what, precisely, the various types of training qualify one to do and not do; 2) attempting to persuade hospitals to group their patients more in accordance with the nursing needs of patients, so as to reduce the likelihood of any nurse being called upon to do something for which she is not properly prepared; and 3) instead of doing away with R.N.A.'s, absorbing them into their professional associations and activities. If diploma and degree trained nurses can exist within the same association, why cannot R.N.A. trained people be included, too? If associations of registered nurses amalgamated with associations of registered nursing assistants, organized nursing would have one voice. The hierarchy of the profession would then be threefold: R.N.A., R.N. (basic) and R.N. (specialist), with a single body made up of representatives from all three areas.

Chapter 3 Conditions of Work in Nursing

Introduction

The relationship between the various conditions under which one works and the way one does one's job is not direct and clear. It has been shown rather conclusively that such age old beliefs as "the more a person is paid the harder or better he will work" and "the happier a person is with his job, the harder or better he will work" are simply not always true.¹ However, such matters as pay, hours, fringe benefits and other working conditions are important. Aside from their significance as socially valued issues in their own right, they have been shown to have considerable influence in attracting and keeping employees.² Obviously, then, they must be discussed at least briefly if one is to appreciate the subsequent analysis of nursing demand and supply.

In this chapter we will deal with the following conditions of work: pay, time worked (in terms of hours, shifts, days off, vacations and holidays), "fringe benefits" and such other conditions as facilities for eating, changing and resting, and policies regarding advancement and job assignment.

It should be mentioned at this point that basic factual data on these matters were found to be much less detailed and complete than we expected. Although the data are available in raw form for hospitals in the various reports which each must submit to the Ontario Hospital Services Commission, they have not always been abstracted and tabulated. In the case of conditions in non-hospital settings, the shortage of province-wide data is much greater — partly because of the diversity of employers; partly because of the absence of requirements on the part of employers to submit data on nurse employees; and partly because bodies who might try to gather such data, such as the RNAO and the Association of Registered Nursing Assistants, have not had the time, budget or qualified staff available to do the job. Had the present research group had more time, we would have liked to do some of this data collection and tabulation ourselves. As it turned out, it was not possible to obtain much beyond the information and impressions gathered during our summer field interviews.

¹For a recent discussion of research and theory on the relationship between money, job satisfaction and work motivation see Saul W. Gellerman, *Motivation and Productivity*, American Management Association, Inc., 1963 (Part II) and Victor Vroom, *Work and Motivation*, Wiley & Sons, New York, 1964 (Parts III and IV).

²Vroom, *ibid.*, Chapter 8.

Pay

Current Conditions

Money has very little significance in absolute terms once one is paid enough to subsist. After this point it has meaning only when one's pay is perceived relative to what is being paid other people and relative to the value of the alternatives which must be foregone to get the pay. For this reason a description of current conditions and trends in wages and salaries has value only when different pay rates are compared to one another. We will examine how pay rates in nursing differ by category, by qualification, by functions, by conditions of work, by employing agency, and by geographic area. It will be seen how difficult it is to make such comparisons because of the uncontrolled influence of one set of factors upon another and because of the inadequacy of existing data.

Basic Nursing Category Pay Rates

Maximum starting salaries approved by the OHSC in recent years are shown in Table 4.

TABLE 4
Average Starting Salaries and Annual Salary Increase Per Cent for Major Nursing Categories, Ontario, 1964-1968

Year	R.N. (General duty)		R.N.A.		Orderlies (Toronto)		Aides (Toronto)	
		Increase from pre- vious year %		Increase %		Increase %		Increase %
1964	335	(3.1)	240	(4.4)	228		225	
1965	355	(5.9)	250	(4.2)	239	(4.8)	235	(4.4)
1966	372	(4.8)	277	(6.8)	248	(3.8)	247	(5.1)
					Untrained	Trained		
1967	400	(7.5)	295	(6.5)	305 (22.9)	317 (27.8)	285	(15.4)
1968	445	(11.3)	325	(11.7)	338 (10.8)	354 (11.6)	315	(10.5)

SOURCE: Data on R.N.'s obtained from the Industrial Relations Department of the Registered Nurses' Association of Ontario based on its wage survey of employing agencies; data on all other classifications based on OHSC approved rates for hospitals financed by the OHSC.

It can be seen from Table 4 that nurses' salaries have improved considerably in the past four years. The increases have been especially large since 1965, when registered nurses first began talking seriously about collective bargaining and the fear of a nursing shortage began to grow. It is interesting also to note the greater proportionate increases given to non-registered nursing personnel in the past two years, presumably reflecting an increasing shortage of such personnel in the labour market or perhaps higher rates negotiated by unionized personnel in this category.

Table 4 presents average starting salaries; and it reflects the belief that, since the inception of the OHSC, there has been a relatively standard rate of pay for nurses across the province, at least at the R.N. level, based on Toronto rates. Though this is more or less the case today, it is a very recent phenomenon. The true variability will be discussed under heading of rates by geographic location.

It is always difficult to evaluate the fairness of salaries by comparing them with those paid in comparable occupations: there are difficulties in agreeing on the criteria of what makes another quite different occupation comparable; there are problems inherent in different pay systems; and it is difficult to compare elements of income not expressed in the basic pay rate. In spite of this, nursing association spokesmen are fond of comparing their salaries with those of school teachers. They argue, with some justification no doubt, that a young woman of high school and leaving age, contemplating a career in two social service occupations like teaching and nursing, might choose the one offering the better salary, other things being equal. That other things are not equal is obvious. For example, the nurse works longer hours, must do shift work and holiday work, and has no summer off; although she has much better opportunities for promotion. On the other hand, both occupations require some formal education beyond high school. The R.N. requires grade 12 plus two or three years for a diploma; grade 13 and four or five years for a degree. The teacher requires grade 13 plus a year of teachers' college to teach elementary school, or a university degree and Ontario College of Education training to teach high school.

Realizing all this, it is interesting to note that in 1967 a "category 3" elementary school teacher (one year at teachers' college plus two years at university) would start at \$433 per month (for ten months' work, with no shift or holiday work) and reach a maximum in that grade of \$767 per month after about thirteen years. The R.N. staff nurse, with *either* a university degree *or* two or three years diploma training, would start at \$400 per month, get two or three weeks' holiday after one year, and have regular shift and holiday duty. If not promoted, she could reach a maximum of about \$480 within two or three years (though in fact most nurses who remain in a given hospital usually obtain one or more promotions). In previous years, the nurse-teacher differential was as great or greater. Clearly the young woman who wishes only to maximize her income while minimizing the time on the job (a situation not uncommon for young single girls) would choose a teaching career over nursing. So too would a woman who wanted merely to practise her profession and not get involved in administration. The increases for years of service in teaching far exceed those offered to nurses. Increases in nursing are awarded only to those who move into administrative positions (such as head nurse). The nurse who wishes to make a life at the bedside offering direct care to the sick must make an extreme financial sacrifice compared to the dedicated teacher who does not want to leave the classroom.

There are no favourite comparison occupations for R.N.A.'s, orderlies and

aides. Suffice it to say, however, that R.N.A.'s are at least better paid than junior typists in Toronto by anywhere from thirty-five to fifty dollars or more a month. On the other hand, "senior typists" (who are often "junior typists" grown older) could be making about fifty dollars per month more than the \$331 the R.N.A.'s make at the top of their grade (according to 1967 data).

Many semi-skilled occupations for males involving several weeks or months of "in-company" training pay considerably better than the rate paid to trained orderlies. Truck drivers in Toronto, for example, earned an average of \$370 per month in 1966, as compared with about \$250 for orderlies. Though many men do in fact raise families on the eighty dollars per week an orderly makes (1967 data), it is understandable how any work paying better could lure the stable family man away from an orderly's job.³

Comparisons of Pay Rates According to Special Qualifications

Graduate nurses not registered. Nurses who have graduated but have not obtained R.N. status are hired by hospitals and allowed to do much, but not all, of the R.N.'s work under qualified supervision. Such staff are usually paid between thirty and forty dollars per month less than the R.N. with the same amount of service.

Possession of one-year certificate, B.Sc.N. or postgraduate degree. In 1967, in theory, possession of special qualifications such as these were worth nothing unless they were "used" — that is, the employee was in a job which was benefited by such training. Thus, if a degree or certificate nurse insists on, or is able to get only, a position as a general staff nurse in a hospital, she will not be paid extra for her post-basic training. On the other hand, most positions beyond general duty nurse in teaching, administration and public health do carry with them a bonus for post-basic qualifications, even though the post-basic training may not be an absolute requirement for employment. These increments for formal qualifications are quite recent; they are variable from one kind of job to another and are not yet universal throughout the province.⁴

Previous experience — general. We could discover no province-wide statistical data on how many employing agencies pay how much beyond basic starting salaries to employees who have had nursing experience elsewhere. We were told by RNAO officials and OHSC consultants that until a couple of years ago the practice was extremely rare. Once a nurse quit an employer she knew she

³All information regarding pay for occupations other than nurses was obtained explicitly for this study by the Industrial Relations Department of the RNAO and is based largely on figures provided verbally from representatives of the Toronto Branch of the Department of Manpower. Clearly these figures must be treated as approximate rather than fully and authentically accurate.

⁴In 1968 the OHSC introduced changes in the scheme for paying bonuses for additional qualifications. Basically this involved increasing the bonus and giving it to any employed nurse with additional qualifications no matter what her job. Unfortunately the existing bonus for nursing school teachers was not increased concomitantly; this resulted in considerable unrest and dissatisfaction within this group.

could expect to start her next job at the going basic starting salary, no matter how long or how valuable her previous experience. In recent years, however, competition for R.N.'s has become stiffer and some hospitals (we do not know how many) are paying anywhere from twenty-five to fifty dollars additional salary per month for one to five full years of past experience. In the case of R.N.A.'s, orderlies and aides, it appears that there is still little or no tendency to pay anything extra for any kind of previous experience.

Previous experience — same employer. If a nurse remains with the same employer, she can expect her salary to increase annually for a certain number of years. In the larger hospitals these increases tend to be automatic; in many of the smaller hospitals, they are based on merit. Depending on how well performance is evaluated by her superiors, the nurse in these smaller hospitals may get none, some, or all of the differential beyond starting salary. Table 5 shows some of the variety in practice concerning seniority pay in 1967. It is based on a representative sample of nineteen hospitals examined expressly for this study by the OHSC.

It can be seen from Table 5 that the amount of differential and number of years it is paid are highly variable in the lower categories and relatively standard at the R.N. level and above — twelve out of twenty pay Toronto rates, and the rest are relatively close. (The standardization at the R.N. level is very recent. In 1964 there was no generally accepted standard at all, and in 1966 only six out of twenty were paying the same amount and duration of differential as Toronto for general duty R.N.'s.) The high variability for non-R.N. nursing staff reflects the belief in hospitals that the supply of labour for such staff is highly localized and hence can reflect local wage conditions. We have no data on the practices of non-hospital employers of nurses.

Comparison of Pay Rates by Function

Beyond the general duty staff nurse are a number of specialized positions which are paid more. For nursing supervisors, for example, the pay in 1967 could range from less than what a general duty staff nurse makes at the top of her grade to as high as \$727 per month. The amount paid depends primarily on the number and complexity of the nursing units supervised. In big hospitals some supervisors have much greater responsibility than a person with the same title in a small hospital. Experience and university degree qualifications add to the rate. (In 1967 the degree added about forty dollars per month to the salary of nursing personnel in administrative positions; a one-year certificate was worth about twenty-five dollars and a six-month correspondence course, fifteen dollars.) Not all hospitals as yet pay extra for additional qualifications among their administrators.

Instructors in nursing schools and head nurses (who supervise a single nursing unit) have positions which are a little more uniform in duties and responsibilities from one hospital to another. Table 6 shows the variability in their salaries among the nineteen-hospital sample drawn for us by the OHSC.

Differentials Paid for Seniority or "Merit" in Nineteen Ontario Hospitals, 1967

Hospital (by location)	Head Nurse (no degree)	Staff Nurse (R.N.)	R.N.A.	Trained Orderlies	Nurse's Aides
Toronto	\$19 per month per year for 5 years	\$16 per month per year for 5 years	\$12 per month per year for 3 years	? (min-max) range = \$20	? (min-max) range = \$36
Hamilton	same as Toronto	same as Toronto	\$9 per month per year for 3 years	\$7 per month per year for 3 years	\$9/3 years
Sault Ste. Marie	same as Toronto	same as Toronto	\$10 or \$12/1 year	\$11 or \$12/1 year	\$10/2 years
Cornwall	same as Toronto	same as Toronto	\$9/2 years	\$9/2 years	\$9/3 years
Peterborough	same as Toronto	same as Toronto	\$13/1 year	\$18/1 year	
Kingston	same as Toronto	same as Toronto	? (\$34 range)	? (\$52 range)	? (\$43 range)
Brockville	same as Toronto	same as Toronto	? (\$40 range)	? (\$40 range)	? (\$40 range)
Stratford	same as Toronto	same as Toronto	\$12/3 years	5%/2 years	? (\$22 range)
	\$15/5 years	\$16/5 years	\$5/6 months	\$6.50/6 months	\$5/6 months
Fort William	\$17/5 years	\$15/5 years	\$10/18 months	\$13/18 months	\$10/6 months
Sudbury	? (range \$95 per month)	same as Toronto	\$12/4 years	? (\$40 range)	? (\$25 range)
Windsor	\$23/5 years	same as Toronto	? (\$45 range)	? (\$29 range)	? (\$44 range)
St. Catharines	\$20/5 years	\$15/5 years	? (\$56 range)	? (\$73 range)	? (\$40 range)
			\$12/4 years	?	\$8/3 years
Sarnia	same as Toronto	same as Toronto	\$7/1 year		
Barrie	\$15/4 years	\$12/4 years	? (\$41 range)	? (\$27 range)	? (\$52 range)
Kirkland Lake	\$14/4 years	\$14/4 years	\$8/3 years	\$10/3 years	?
Oshawa	same as Toronto	same as Toronto	\$8/3 years	\$12/1 year	\$11/3 years
London	same as Toronto	same as Toronto	? (\$30 range)	? (\$40 range)	? (\$35 range)
Ottawa	same as Toronto	same as Toronto	\$12/3 years	? (\$30 range)	? (\$20 range)
Kitchener	\$15/5 years	same as Toronto	? (\$30 range)	\$18/3½ years	\$16/3½ years
		\$15/5 years	\$12/3 years	\$12/3 years	\$10/3 years

SOURCE: Ontario Hospital Services Commission.

Table 6 demonstrates several interesting points. Instructors and head nurses are paid much the same to start, although instructors usually can progress a little higher in their classification than head nurses. The range of rates varies greatly from one employer to another at both the bottom and the top of the scale. In almost all cases it is possible for a regular general duty R.N. with seniority to make more than the lowest-paid head nurse or instructor.

TABLE 6
Monthly Salary Ranges and Differentials for Head Nurses and
Nursing School Instructors in Nineteen Ontario Hospitals, 1967

	Range of Lowest Rates Paid (start- ing; no de- gree)	Range of Highest Rates Paid (degree and experience)	Median of Start- ing Rates	Median of High- est Rates	Differential between rate for position and top rate for General Duty R.N.'s		
	From—To	From—To			Lowest differ- ential	Highest differ- ential	Median differ- ential
Instructors	\$455 — \$580	\$560 — \$648	\$465	\$635	—\$20	+\$100	—\$15
Head Nurses	\$445 — \$468	\$515 — \$633	\$465	\$580	—\$40	+\$ 12	—\$15

SOURCE: Ontario Hospital Services Commission.

The data for public health nurses (with public health certificates or better) are inadequate, but the RNAO reports that the range of starting salaries for such nurses in 1967 was from \$408 per month to \$474. The median or modal rate is not known.

Nurses have recently begun to press for the recognition of “clinical specialists” in nursing. Such nurses would carry out highly complex specialized nursing procedures or play the role of expert consultant to regular nurses on nursing problems associated with certain types of illness or with certain types of patients. To date, we know of only one hospital which has attempted to implement “clinical specialist” positions, and it was forced by the OHSC to classify them formally as supervisory positions. A few hospitals pay a bonus to nurses who specialize in certain complex and highly sensitive areas such as operating room or intensive care units. As yet, however, any sort of pay differential based on the type of nursing done is extremely rare.

Comparisons of Pay Rates as Affected by Conditions of Work

Though most employees in industry who work shifts are paid some sort of shift differential, most nurses are not. According to information given to the RNAO by members, in a few cases in the past some hospitals have “unofficially” (without OHSC consent) paid a shift differential of ten or fifteen cents an hour during summer months as an incentive to retain staff. A very few unionized groups of

non-R.N. nursing staff have negotiated small differentials. In 1968, however, the official ban on shift pay was broken: the OHSC now authorizes a hospital to pay up to one dollar per shift extra to graduate nurses working evening and night shifts. It is not yet known how many hospitals will adopt this practice. As the ruling does not extend to lower level or supervisory staff, there will likely be some interesting grumbles among such staff when the general duty differential is paid.

Regarding overtime pay, the practice is not to pay for overtime but to compensate staff who work overtime by giving them equivalent time off. This holds for all levels and classes of nurse except for the same few unionized non-R.N. groups who have negotiated time-and-a-half rates for any work over eighty hours every two weeks.

Comparisons of Pay Rates by Employing Agency

It is widely believed that nurses' salaries are quite uniform throughout the province, at least in the basic categories. Unfortunately this belief has not been tested against the data. There have been no comparisons of the rates paid general duty staff nurses or R.N.A.'s, for example, in public, private or federal general hospitals; in TB sanatoria, mental hospitals, rehabilitation or chronic care hospitals; in public health agencies of various types; in nursing homes; and among private employers such as doctors, clinics, industries or individual citizens. The probability is that the range of salaries is quite large. We know, for example, that in 1967 an R.N. who worked as a private duty nurse in Toronto could make twenty-two dollars per day or about \$470 per month if she worked regularly for five days a week (an R.N.A. could make sixteen dollars per day or about \$340 per month). Even within the category "public general hospital" and among hospitals of similar size, the starting rates and ranges for R.N.'s can vary as much as ninety dollars per month from one employer to another, depending largely on geographic location. (However, it should be admitted that since 1965 and the first serious threat of nursing unionization, there has been a steadily declining number of hospitals willing to pay less than Toronto rates for basic R.N.'s — only two in over fourteen hospitals sampled for 1967 as opposed to nine in 1964.)

In the case of R.N.A.'s, orderlies and nurse's aides, who are viewed as belonging to local labour markets, the range of rates is much greater. For example, among the nineteen hospitals sampled for us by the OHSC there was a range from \$246 to \$317 for R.N.A.'s in 1967 and a weaker modal tendency than in the case of R.N.'s. The lack of uniformity was even greater for trained orderlies.

Comparison of Pay Rates by Geographic Area

Table 7 shows some of the variations in salaries for the major nursing categories between different parts of the province in 1967 using the sample of nineteen general public hospitals drawn for us by the OHSC. For R.N.'s it can be seen that Windsor (which faces stiff competition from high-paying Detroit) and Kirkland Lake (an isolated northern town) both pay above the standard starting and top

salaries. The local labour supply from which R.N.A.'s, orderlies and nurse's aides are drawn is reflected in the range and deviation from "Toronto rates": for example, for R.N.A.'s a range of from \$246 to \$317 with 63 per cent of the hospitals deviating by more than five dollars from the Toronto starting rates; for orderlies a range of from \$265 to \$410 with 58 per cent deviating by plus or minus five dollars from the Toronto rate; for nurse's aides a range of \$192 to \$285 with Toronto paying the top rate and no one coming within five dollars of it. (It should be noted, incidentally, that the diversity of orderlies' and aides' wages is increased by the lack of standard qualifications or job descriptions for these positions.)

TABLE 7
Variation in Monthly Nursing Salaries by
Locality Within Ontario, 1967

Location	Head Nurse—R.N.		R.N.A.		Trained Orderly		Nurse's Aide	
	Low	High	Low	High	Low	High	Low	High
Toronto	\$400	\$480	\$295	\$331	\$319	\$339	\$285	\$321
Hamilton	401	482	317	335	339	356	274	291
Oshawa	400	480	293	323	318	358	252	287
London	400	480	295	331	324	354	272	292
Sarnia	399.97	480.03	246	287	320	347	208	260
St. Catharines	400	480	276	331	314	332	218	242
Windsor	405	485	266	322	337	410	236	280
Kitchener	400	475	Male 305 Fem. 280	341 310	315	351	Male 280 Fem. 245	310 275
Stratford	400	480	281	296	316.50	366.50	257	272
Ottawa	400	480	?	?	318	363	260	306
Brockville	400	480	295	331	294	340	218	240
Kingston	400	480	275	315	295	335	220	260
Peterborough	400	480	278	312	283	335	248	291
Cornwall	395	475	295	325	299	334	217	264
Barrie	390	438	250	275	265	295	?	?
Kirkland Lake	415	485	285	315	275	300	200	250
Sudbury	400	480	291	336	316	345	258	302
Fort William	400	475	258	306	278	318	192	217
Sault Ste. Marie	400	480	273	294	341	361	234	257

SOURCE: Ontario Hospital Services Commission.

Comparing the wages for nurses in Ontario with those in the other provinces, it appears from data gathered by the RNAO that in 1967 on average Ontario paid the highest starting salaries for R.N.'s. Even in British Columbia, where nurses bargain collectively for their rates, the salary was only \$390 per month as against Ontario's \$400. According to RNAO officials, however, at the time of writing, the salary lead will be lost in 1968; British Columbia and perhaps Alberta are expected to equal or surpass it in spite of the large increases introduced in Ontario for 1968.

To the extent that disproportionate numbers of Canadian nurses might be lured to the United States by higher wages, it is worth briefly comparing the United

States and Ontario rates. Since there are no state-wide hospital systems, the picture in the United States is one of extreme diversity among regions and among hospitals. This makes comparisons difficult. However, Table 8 indicates some of the approximate differences between averages in 1966. Though these differences might well be somewhat less in 1969, it can be seen that there is roughly a 7 per cent differential between Ontario and her immediate neighbours in the north central states, with a slightly larger difference in comparison with the eastern seaboard. Whether the elimination of this differential would lessen the numbers of nurses who emigrate to the United States is, of course, impossible to say. From our interviews with nurses, it was our impression that parity would not eliminate emigration by any means. Young R.N.'s go to the United States "for the experience", "to go somewhere different", "because they give you real responsibility and treat you as though you were important down there". Money, when mentioned, tended to be added as a secondary factor along with benefits such as "inexpensive accommodation supplied by the hospital" and "longer vacations".

TABLE 8
Differences in Average Monthly Starting Salaries for Nursing Personnel
Between Ontario and Major United States Regions, 1966 (Non-federal Hospitals)

Nurse Classification	Ontario	United States			
		West	North East	North Central	South
R.N. General Duty	\$372	\$442	\$404	\$400	\$362
R.N.A. (or equiv.)	277	326	320	302	246
Nurse's Aides	212	276	262	228	188
	(approx.)				

SOURCE: American Nurses' Association, *Facts About Nursing*, 1967 edition, pp. 138, 189.

Decision Structure and Process Regarding Pay

The decision structure on matters of nursing salaries is somewhat loose and informal. Officially, the responsibility for pay decisions rests with the chief executive of the employing agency and its governing board (if it has one). In fact, in the case of hospitals, the Ontario Hospital Services Commission "informally" sets upper limits or guide limits to the pay scales for each classification each year, and each hospital is free to decide what it will pay as long as it is not over the maxima. Attempts to pay above the maxima for R.N.'s usually are turned down by the OHSC when the hospital submits its budget, though they may be approved if the hospital can cite extenuating circumstances. In the case of non-R.N. staff, the OHSC expects fewer than 20 per cent of the hospitals to pay at or near the upper limits.

How does the OHSC arrive at its upper limits on nursing salaries? The process involves discussion and negotiation with a relatively little known body called the Toronto Hospital Council.

The Toronto Hospital Council was created in the late 1940's at the urging of the OHA, primarily as a means for hospital trustees to get together and discuss common problems. Until 1967 its structure consisted of a council of representatives of the boards of the public general hospitals in the Metro Toronto area, and an Administrators' Committee made up of the administrators of these hospitals. It has no formal connection with the OHA, although all its members are also OHA members.

As it turned out, the trustees' group was rather inactive, while the administrators' group met monthly and set up a number of standing subcommittees dealing with personnel, accounting, housekeeping, pharmacy and nursing salaries. A small subgroup of nursing directors also met occasionally under the auspices of the Council to discuss common problems.

In 1967 the structure was changed, and now administrators are admitted as part of the overall Council. The various administrators' subcommittees are still active, however. Also in 1967, the Committee on Nursing Salaries broadened its scope to include all the paramedical occupations that work in hospitals.

Committee membership rotates each year. It is usually made up of administrators from five Toronto hospitals, plus one representative from the Personnel Committee of the Council. One of the administrators is chosen as chairman. The main function of the Committee is to make recommendations for all classes of nursing salaries up to, but not including, the director level.

The following information is used:

- 1) A survey of wage rates paid during the previous year throughout the province.
- 2) A study of current rates being paid in Montreal and Vancouver.
- 3) A study of current rates being paid in major centres in the United States.
- 4) The recommended rates published by the Canadian Nurses' Association, the RNAO, and the American Nurses' Association and League of Nurses in the United States. In 1967 the ANA was asking for a basic wage of \$6,500 per year and the CNA for \$6,000 per year basic. The RNAO in January published lower recommended rates, but at the March convention the membership moved that they demand the same as the CNA and the rates were revised upward.
- 5) A meeting is held with a few nursing directors from the main Toronto hospitals to get their opinions on what the rank and file feel they should be getting.

- 6) The Council's Personnel Committee engages in job evaluation studies, the outcome of which is a *ranking* of the paramedical occupations in terms of the salaries they merit. This Committee draws on previous rankings done by a group of management consultants several years ago at four Toronto hospitals (sponsored by the OHA) and another ranking study done by the personnel consultant in the OHSC.
- 7) In 1967, for the first time, the Committee had access to an annual salary survey conducted by the OHSC.
- 8) Cost of living data.
- 9) Settlements from collective bargaining. Until 1967, no *large* Ontario hospital negotiated its salaries with nurses' associations, but the Committee reviewed the two existing agreements involving hospital nurses and all those between public health units and organized public health nurses.

The Committee mulls over the inputs from all these sources of information then, as one member of the Committee put it, "usually ends up making some 'seat of the pants' judgements about the actual amounts". In 1967, for example, in spite of job evaluation studies and survey results, they decided to recommend a 12½ per cent increase in starting salaries for nurses (from \$400 to \$450) for 1968, primarily because of political pressure to attract more nurses into the hospitals.

Once the subcommittee has produced its report (usually by June), it is passed by the Administrators' Committee, then by the Council as a whole; and finally it goes to the OHSC where it is informally negotiated.⁵

While the Toronto Council prepares its recommended rates, the chief personnel consultant at the OHSC carries out a thorough salary survey and arrives at his predictions regarding the eighth and ninth deciles of the salaries expected to be paid throughout the province in the following year. These form the basis of his guide limits, which are sent on to the head of the Hospital Standards Department of the Commission.

The two sets of data and recommendations are pooled by top level members of the OHSC and Toronto Council representatives, and together they negotiate a settlement in those areas where the recommendations differ. (However, according to information from both the Committee and the Commission, the recommendations are usually quite similar and the differences to be negotiated small.)

⁵All information on the activities of the Toronto Hospital Council and its Nursing Salaries Committee was obtained from an interview with the 1967 Chairman of the Nursing Salaries Committee.

Once the preliminary negotiations are over, the Council's Salaries Committee apparently drops out of the picture and the agreed upon schedule is taken before the OHSC Executive Committee for final approval. They do not usually oppose the recommendations. When approval is received at this level, the salary scale is informally used as the criterion for approving the salary budgets for the individual hospitals. The OHSC does not publish the scale as "official" or "approved" rates. The hospitals find out, however, through the OHA, which acquires the agreed upon recommendations from the Toronto Council's Salaries Committee and publishes them province-wide.⁶

The above description outlines the procedure by which nursing salaries are arrived at, but it does not discuss in any depth the influences which shape the final decision. Undoubtedly the biggest single factor is the labour market in terms of supply and demand. While the Toronto Council Salaries Committee has not felt that there has been a severe nursing shortage in the past in Toronto, they, along with most administrators, have felt there has been a noticeable shortage, a growing difficulty in getting nurses in the past two years; and most significantly, they see a real problem in attracting staff by 1970 when approximately 900 new beds will have been opened in the Metro area.

After talking with a number of persons connected with hospital administration, one also gets the impression that collective bargaining for hospital nurses, or the threat of it on a wide scale, has had its effect. Coincidental with the perceived shortage problem, in 1965 the RNAO finally committed itself to an all-out effort to organize nurses for bargaining purposes. Since then, about twenty-two public health units and nineteen hospitals have been organized, and seven public health and two hospital contracts have been negotiated. The effect of negotiations on public health nurse salaries apparently has been substantial. Prior to 1965, these nurses received very little or no differential above the basic hospital R.N.'s starting salary. Since 1965, the differential has increased to about thirty dollars per month.⁷ This substantial increase in public health nurse salaries, arrived at outside the influence of the OHSC and the Toronto Council, could quite likely have extensive pulling power on the rates for hospital nurses.

While the Toronto Council and OHSC set maximum nurses' salaries, each hospital is free to decide to pay below those rates. The individual hospital is also the prime determinant of whether to pay differentials for experience, qualifications, shift work, overtime, and the like. Here one gets the impression that a strong conservative attitude prevails among administrators and/or their boards of trustees.

For example, the author was told by one administrative official of a situation known to him in one small town where many of the hospital board members were

⁶See, for example, *Hospital Administration in Canada*, November 1967, p. 24.

⁷See "Nurses' Salaries: Before and After", *RNAO News*, Vol. 23, No. 5, November-December 1967, p. 19.

also local businessmen who had to compete with the hospital for labour. As a result, they apparently put pressure on the administrator to keep hospital salaries in line with local pay rates. It is not inconceivable that such a situation could exist in other locations outside the big cities. We also asked those hospital administrators that we spoke to how much they still viewed themselves as guardians of the purse strings in the way they had to be back in the days when hospitals were privately financed. A surprising number of them stated that the advent of centralized public financing had not changed their strong cost consciousness in administering the hospital's funds.

As for the OHSC, its official policy is to allow the individual hospital as much independence as possible, while trying to improve and maintain acceptable standards of care. There is thus a certain amount of inherent and inevitable dynamic tension or conflict within the OHSC between these two goals of encouraging independence (with concomitant tacit approval of hospital administrators' efforts to keep costs low) on the one hand, and of trying to influence hospital standards (with the concomitant need to occasionally urge hospitals to spend more money) on the other. This tension is reflected in the internal operation of the OHSC where consultants in the various aspects of hospital care belong in one department and are interested in standards first and costs second; and financial experts, who are interested primarily in keeping costs in line, belong in another. Each group spends a great deal of time trying to educate the other to its point of view. Occasionally internal battles break out, usually over matters of the number and quality of staff needed in a particular hospital.⁸ The net effect of this dynamic tension within the OHSC is that the financial experts usually do not advise hospital administrators to boost wages in order to come into line with others, while various consultants may suggest to the hospital department heads with whom they spend their time that some of their problems might be eased by increasing salaries. This places the resolution of conflict within the executive committees of each hospital. Since we have already seen that the power and influence of the nursing director within the councils of the hospital is often quite weak, it can be realized how a penurious administrator and/or board of trustees could inhibit new policies regarding various differentials or maximum rates.

Opinion on Nursing Pay

As might be imagined, professional nurses' associations feel that current pay rates, though they have improved greatly over the past four years, could be improved still more. What concerns them just as much as the basic starting salary, however, is the lack of differentials beyond it. They feel that all employing agencies should pay extra for experience and for qualifications beyond basic

⁸Several examples of the dynamic tension between consultants and financial experts were mentioned in confidence by various OHSC officials interviewed. It should not be thought, incidentally, that these differences of opinion were bitter or irrational. They simply reflected honest disagreements based on the differing orientations of the two kinds of positions.

training. They would like to see special rates paid for trained clinical specialists and larger differentials paid to head nurses, supervisors and teachers. Shift differentials and overtime pay (rather than straight time off) also are felt to be necessary before nursing occupations can compete financially with alternative forms of employment for female high school graduates. And they believe that substantial numbers of males will not be attracted into the profession, nor will large numbers of non-practising nurses be attracted back to work, at present rates.

The preferred means for deciding pay matters, as well as all other terms of employment among nursing leaders, has come to be that of collective bargaining between an association of nurses and the employing agency (the details of the nature of this bargaining relationship will be discussed later). Although the spirit of agreement on the desirability of collective bargaining for nurses is now almost unanimous among nursing leaders, it should be recognized that it has come about only within the last few years and only after much soul-searching and heated debate within the profession (including systematic attempts to organize a rival professional organization to the RNAO to push more vigorously for bargaining). On the other hand, a number of senior practising nurses, mostly in administration, still have grave reservations about the whole bargaining trend.

Among hospital administrators, there is no noticeable dissatisfaction with the current trend in nursing salaries; but there is a feeling of annoyance with the current procedure for arriving at upper limits among a certain number of administrators in large centres outside Toronto. Some would like to be able to pay above the upper limits in certain cases, because of the pressures of certain local conditions, but feel they cannot. As one alternative, several we interviewed would rather see each major region in the province sitting down with the OHSC to discuss the best rate structure on a regional basis.

Time

Current Conditions

Shifts and Days Off

Although there are some problems with pay policies in nursing, the condition of work which appears to give rise to the greatest amount of difficulty among nurses is the time they work. In particular, they get upset about the scheduling of shifts and days off.

The fact of the matter is that the nurses' work period is eight hours per day for an average of twenty days per month. (One cannot say five days a week, instead of twenty days a month, because in many hospitals nurses do not work five days on duty and two days off. Duty spans of seven or nine days between days off are not uncommon.) In the only two small Ontario hospitals in which

R.N.'s have negotiated a collective agreement with the hospital, hours per week are thirty-eight and three-quarters and thirty-seven and one-half, respectively. R.N.A.'s and orderlies, both under union contract and not, put in a forty-hour week.

In the case of the allocation of shifts, there is wide variability in the shift rotation schemes used. Some common patterns in the hospitals visited include:

- 1) Four weeks days; two weeks evenings; two weeks nights.
- 2) Three weeks days; two weeks evenings; one week nights.
- 3) Six weeks days; two weeks evenings; two weeks nights.
- 4) Four weeks days; four weeks evenings; four weeks nights.

In no hospital was there a system of stable shifts in practice other than for a few selected individuals. Split shifts could be found in only one hospital of those we visited.

Hospitals varied also in the amount of advance notice given to staff of the shifts and days they would be working. On average, work schedules are made up at least a month in advance; but the range varied from three months in one hospital to one week advance notice in another. (This latter situation may have been due to a difficult period of staff turnover at the beginning of the summer.) Most hospitals do their best to accommodate requests from staff for days off which are different from those scheduled, but again there is variation from one hospital to another and, for that matter, one unit to another within the hospital, depending on the benevolence of the head nurse in tolerating or being able to accommodate such practices.

A particular problem with regard to hours is caused by the employment of part-time staff. Some hospitals are very loath to even hire this type of employee if they can possibly avoid it, primarily because of the problems of scheduling them in an equitable fashion. Some hospitals will hire part-time nurses *only* if they will work night shifts or rotate shifts like full-time staff. In a few hospitals, the policy is to allow a part-time employee to remain on a particular shift as long as she can be matched by part-time employees remaining on the other shifts. Finally there are at least some (but an unknown number of) hospitals in which part-time staff are allowed to work days only, even though full-time staff rotate shifts.

Vacations and Holidays

In the case of vacations, the picture again is one of variety. They range from two to four weeks a year for employees with six months' seniority. The common pattern is two weeks a year with three weeks after a specified number of years (anywhere from one to ten). R.N.A.'s and orderlies get about the same length of vacation as R.N.'s, although some R.N.A.'s get only ten days as opposed to the R.N.'s two weeks. Paid holidays per year range from seven to eleven, with

nine being the most common number. Employees in hospitals run by religious orders may get additional holidays. As is the case with hours, the scheduling procedure for vacations can be as frustrating as the short vacation period. Common complaints are that vacation and holiday schedules are drawn up too late, too little attention is paid to personal preferences, there is inadequate consultation between staff and administration on the matter, and so on.

Decision Structure and Process

The point where decisions are made about time allocation is almost as variable as the patterns of allocation themselves. Basic policies regarding rotation systems, days off, vacation schedules, and so on usually are decided at the director of nursing level. She works only within the constraints of hospital personnel policy regarding the number of hours a person may work, number of days off, number of vacations and holidays. These overall personnel policies usually are decided by the administrator in consultation with his personnel office, if he has one, and the executive committee. Within the scheduling policies set by the director, the actual drawing up of schedules for staff is done by either the head nurses, or the supervisors, or, in smaller hospitals, by the director herself. Sometimes they are done jointly by the supervisor and her head nurses. Sometimes the director insists on personally checking and approving each week's schedules; sometimes only the supervisors do this.

While size of the hospital appears to be the major factor affecting the degree of involvement of the director in drawing up schedules, the director's overall style of management also is influential. Centralized, authoritative directors want to oversee every detail of administration. Decentralized, participative directors permit the decision-making authority to rest as far down the hierarchy as practicable. In the extreme case, schedules are set up by the work group itself with head nurses acting at best as meeting leaders.

Since the variation in practice is so great, it appears that the influence of provincial bodies such as the OHSC, the OHA or the RNAO is quite weak. Indeed, we could detect little, if any, effort among these bodies to develop uniformity in any of the personnel policies looked at, with the exception of pay matters. Since the decision-makers for their part usually make little effort to formally consult the employees to learn their attitudes or desires, decisions are made mainly on the basis of past practice or of some set of beliefs about "local conditions" for employees of all classes and kinds in a variety of businesses and other organizations. But even "local conditions" often do not provide an outside reference point for policy decisions on rotating shifts or days off for female employees.

Opinion on Time

It has already been indicated that problems in the allocation of time give rise to more dissatisfaction among rank-and-file hospital nursing staff of all classes than

any other single issue. Many nursing spokesmen maintain that the requirement of shift work and weekend and holiday work is a prime factor in turning prospective nurses away from the profession and causing practising nurses either to retire from nursing or at least to seek non-hospital work.

As will be seen in the section on nursing education, many critics of both university degree programs and new forms of diploma education complain that they exacerbate the time problems by not adequately preparing the future nurse to adapt to and accept the round-the-clock nature of the work; for student nurses are not required to work night shifts, weekends or holidays to any appreciable extent while they are training.

While virtually everyone sympathizes with the nurse's plight, there is little that can be done to change the basic system. It is surprising, however, that there is not much more consultation and exchange of information regarding ways of making the scheduling of hours and vacations as acceptable as possible to employee groups. If and when collective bargaining becomes province-wide, perhaps this improvement in information flow and consultation will take place.

Fringe Benefits

Current Conditions

The fringe benefits looked at were medical, life insurance, and pension plans. Again, the picture is one of diversity. We will not go into detailed differences among the benefits offered by the various plans adopted by hospitals but will discuss only who pays for them. In most cases, the hospital pays 50 per cent of a life insurance plan. Some plans are compulsory and some voluntary. The eligibility period may be anywhere from three months to one year after employment, depending on the plan. In one of the hospitals where R.N.'s are organized, the employer pays a full 100 per cent of the cost.

In the case of medical-surgical plans, the common pattern again is a fifty-fifty cost sharing between employer and employee, although again the same organized hospital pays 100 per cent of the R.N.'s participation. Law requires that nurses be given free medical check-ups and that hospitals retain an employee nurse to whom all hospital staff report if taken ill or injured on the job.

Most hospitals subscribe to the pension plan organized and operated by the OHA and pay for this, too, on a fifty-fifty cost sharing basis with employees. Eligibility for the plan varies, depending on the hospital and employee classification.

Although we did not examine the matter thoroughly, it appeared that nurses employed in large government, educational, industrial and visiting nurse organizations receive amounts and terms for the major fringe benefits discussed above similar to those obtained in the average hospital.

Decision Structure and Process

On all matters involving direct expenditures of money by hospitals, the OHSC has the ultimate say about whether or not the money will be provided. For this reason, there is a little more uniformity in the terms of pensions, insurance and medical plans than is the case with hours of work. As noted in the case of wages, however, the OHSC primarily enforces upper limits and does little to pressure hospitals into maintaining a uniform standard on such matters. This leaves numerous details of the benefit plans in the hands of the administration and boards of trustees. The OHA circulates the details of significant union contract settlements which provides some guidelines about what other hospitals are doing; but there is no complete, detailed, systematic and regular exchange of this information. In fact, this type of information could be provided quickly and economically only by means of a computerized information storage and retrieval system.

Opinion on Fringe Benefits

Nurses, like most other employees, care little about fringe benefits except when they do not have them or when they suddenly need them. The newly militant RNAO, in its role as chief instigator of and advisor to collective bargaining associations for nurses, is deeply concerned about such matters, however, and feels there is room for considerable improvement in the terms of almost all existing benefit plans.

Other Working Conditions

Current Conditions

Under "other working conditions" we will consider such matters as sick leave; lunch and rest periods and facilities for these; policies regarding promotions; performance evaluation and intra-agency transfers. Questions of training and development programs for nurses will be discussed in the section on education.

In the case of paid sick leave, there is little variation in the amount (from one to one and one-quarter days per month) from one employing agency to another. The variation arises in the amount which is allowed to accumulate. Here the range is from thirty to 180 days. All but a very few hospitals do not pay for unused sick leave.

Lunch periods vary from forty-five to sixty minutes and breaks are two per shift, lasting from ten to fifteen minutes. All hospitals possess staff eating facilities, but provision of special lounge facilities for employees is much more variable.

Policies regarding promotions, performance evaluation and concomitant merit pay increases, and intra-agency job transfers are highly variable from one employing agency to another. The impression gained on our visits was that these are

very much in need of systematic study, both in terms of classifying the criteria to be used in deciding promotions, evaluating performance and evaluating transfer requests, and in terms of training supervisory staff in performing these functions. Too many staff nurses view these activities as being carried out in a rather haphazard and capricious fashion.

Decision Structure and Process

Again, these matters are decided at the employing agency level. Within the agency, the amount of discretion provided to the various levels of the hierarchy from administrator to head nurse is extremely variable. The most common pattern is that policy is set by the administrator and his executive committee, with the director of nursing and the personnel manager (if there is one) playing a major advisory role and perhaps having a vote on the committee. Application of the policy to individual cases rests with the head nurse, supervisor or director, depending on the degree of delegation permitted by the director.

Summary

The most striking feature which emerges from this brief and general look at the more significant conditions of work affecting nurses in Ontario is the immense variation in them from one employing agency to another. This is due primarily to the fact that the power to decide these matters lies almost unilaterally in the hands of the top executive group within each employing agency. Only in the case of conditions for which there are direct costs, such as pay and certain benefit plans, is direct control exerted outside the agency by organizations such as the OHSC. Even here, the control is in the form of upper limits.

Although diversity due to decentralized unilateral decision-making is the present picture, it does not look as though it will be so for much longer. The force which is leading to change, of course, is the growth of collective bargaining for nurses. As collective bargaining becomes established on a province-wide basis and one key employee organization negotiates for the great majority of nurses, decision-making will become bilateral and uniformity of conditions will appear, as both sides initiate massive programs for gathering and disseminating information.

Registered nurses in Ontario have only recently started to move into the collective bargaining area, after years of agonizing soul-searching and conflict within the profession. Even today there is still an unknown proportion of older R.N.'s who feel it is basically unprofessional for nurses to form a union or bargain collectively. R.N.A.'s have only very weak occupational associations. Orderlies and aides have none. Although about 50 per cent of these non-R.N. nurses come under collective agreements, they are included as only one group in a general non-professional employees' union. These non-professional unions may be independent or affiliated with large national bodies such as the Canadian Union of Public Employees.

Registered nurses have so far resisted becoming a part of a general union within the employing agency. The present system is for nurses in each agency to form, in effect, a local independent union of R.N.'s only. Even R.N.A.'s, their closest co-workers, are kept out. The local "association", as it is called (the word "union" is anathema to nurses), then seeks voluntary recognition by the employer or gets official certification as a bargaining agent by the Ontario Labour Relations Board. The Registered Nurses' Association of Ontario as it is presently constituted is not legally permitted to act as a bargaining agent for nurses because its membership includes nurses who are members of management. What they do, therefore, is to offer voluntary advice and assistance to the independent local associations in organizing, negotiating and administering contracts. In return for this, association members contribute fifty dollars per year to the RNAO Central Security Fund (or fifteen dollars per year if one is already an RNAO member and has paid the thirty-five dollars annual membership fee). The RNAO fully and officially supports the policy of excluding R.N.A.'s from local R.N. associations.

The general system of collective bargaining for nurses in Ontario differs sharply from two other patterns of bargaining existing in Canada. In British Columbia, there has been centralized, province-wide collective bargaining for R.N.'s for about twenty years. An amendment to the British Columbia Labour Relations Act has permitted the B.C. Registered Nurses' Association to be recognized as a legal bargaining agent for R.N.'s. The BCRNA negotiates a master contract with the B.C. Hospital Association covering R.N.'s in sixty-two hospitals and thirteen public health agencies. Local agreements based on the master contract are then negotiated by each employer and association local. There is no compulsory arbitration in the case of stalemated negotiations, but strikes of nurses are extremely rare and there have been no official province-wide work stoppages.

In Alberta, the Alberta Association of Registered Nurses has amended its constitution so as to create, in effect, a separate body made up solely of non-managerial nurses (defined by the Alberta Labour Relations Board as all nurses below the level of supervisor). The constitutional amendment has permitted the AARN (or at least this separate branch of it) to act as a bargaining agent in negotiations. Unlike B.C., however, there are no central, province-wide negotiations in Alberta. Each employer bargains separately with each local AARN branch. The only form for uniform conditions, therefore, is the efforts of the AARN to gain acceptance of centrally developed contract proposals in each and every local negotiation.

In Ontario, since 1965 the RNAO has been attempting to obtain a "B.C.-type" bargaining model in which it would negotiate for all organized R.N.'s on a province-wide basis, with the Ontario Hospital Association acting for the employers. Efforts to obtain the necessary amendment to the Ontario Labour Relations Act have so far been unsuccessful. As well as there being no provision for the RNAO to act as a bargaining agent, there are not even any uniform criteria as yet

regarding who should be included in the bargaining units for local associations. In some cases, everyone up to and including supervisors is involved although commonly not even head nurses are included.

In spite of the lack of clear policies and firm support in public policy at the provincial level, 1967 saw a sudden burgeoning of collective bargaining activity among R.N.'s in Ontario. Of the fourteen hospital nurses' associations which were either certified or applying for certification as of December 1967, all but two were new in 1967 and these two obtained their certification in 1966.

In the case of public health units, there are currently twenty-two nurses' associations, all formed since 1966. Five of them have received voluntary recognition and have therefore not applied for certification; twelve have been certified by the Labour Relations Board; and the remainder are in various stages of obtaining recognition either legally or voluntarily. With the organization of associations in the largest hospitals in Ottawa and Hamilton, it would appear that the back of resistance to organization is about to be broken (although it is significant that so far only one small hospital in the Metropolitan Toronto area has been organized).

If we can assume that it is only a period of a few years before the wages, hours and working conditions of R.N.'s (if not R.N.A.'s and orderlies) are negotiated province-wide by the RNAO and the OHA (or at the least that these two bodies play key roles in local negotiations on the majority of employing organizations), where will this leave the OHSC? At present, it is the final arbitrator of maxima because of its control over hospital budgets, and there is little organized opposition to its decisions. So far, it has been willing to accept without question the settlements negotiated in the two hospitals which have actually undergone collective bargaining with nurses. In the future, with the majority of the largest single component of the non-medical labour force bargaining, the Commission probably will not be able to do this. Though officially it must remain outside the bargaining process, it seems to us inevitable that it will have to become involved unofficially. This will probably take the form of informally communicating to the employer group what, in very general terms, the Commission will be able and willing to pay for nurses' salaries and benefits in a way not dissimilar to the present informal negotiations between the Commission and the Toronto Council. All that bargaining will add will be the risk that the nurses will not accept the maxima and will engage in some form of collective action.⁹

As is the case with so many newly established collective bargaining relationships, the greatest immediate benefit to be derived for the employees may be not

⁹It is interesting to note, incidentally, that the Province of Manitoba *Report of the Minister of Health's Committee on the Supply of Nurses* (November 1966) has recommended that the Manitoba Association of Registered Nurses be authorized to act as the bargaining agent for member nurses (pp. 72-73).

so much greater monetary rewards but improved non-monetary working conditions and an evening out of variation between regions and employers. There is bound to be an increased flow of information regarding systems for scheduling work; allocating vacations; deciding on promotions, transfers, and merit increases; and a dozen other personnel policies and practices. Pressure will be placed on the least satisfactory institutions to measure up to the provincial standard.

The key to whether these non-monetary benefits of collective bargaining are realized, however, depends entirely on the degree of maturity and responsibility with which the two parties approach each other. It is possible to bargain yet still possess a basic attitude of trust and respect for the other side. If this atmosphere prevails, the whole climate of personnel relations could improve. If it does not, monetary conditions may improve, but rigidity and hostility will come to characterize the handling of all other matters between the parties within the employing agencies.

In the last analysis, the collective bargaining climate at the local level is strongly affected by the climate at the provincial level. At present, the state of this climate does not augur well for the future of large-scale nurses' bargaining. The OHA and the RNAO currently share very little indeed in the way of mutual trust and respect. Communication between the two bodies, even at an informal level, is almost absent and when it occurs is more like an encounter between Red Chinese and U.S. diplomatic officials. Unless a new maturity develops, this atmosphere is bound to filter down to the local level and severely disfigure the sensitive collective bargaining relations developing there.

Chapter 4 Supply and Demand in Nursing

Introduction

The question of a nursing shortage — whether there is one, and, if so, how great it is and what is the exact nature of it — is undoubtedly the most controversial issue, not so much *within* the nursing profession, but *between* it and other groups and organizations with an interest in nursing service. The prime reasons for the sensitive, emotional nature of the issue are its complexity and the immense scarcity of good data on the subject. The complexity is to be found in all facets of the issue: How can supply and demand be most objectively and usefully measured? *If* demand exceeds supply, why is this so? What are the best means for balancing the two?

One would expect that the difficulty of formulating good answers to such complex questions would be so apparent that large amounts of time and effort already would have been spent on continuing studies to gather and analyze as much basic data as possible on the present and future state of both the supply and demand sides of the problem. On commencing our study we certainly expected no difficulty in obtaining previous studies on “the shortage” from the bodies most directly concerned with nursing: the RNAO, the College of Nurses, the OHSC and the OHA. Imagine our surprise, therefore, on discovering that the amount of tabulated statistical information available was most scanty, and more than a little confusing and disorganized. Visualize our even greater surprise on discovering that, in spite of the low state of factual knowledge, the conclusions had already been reached among the chief decision-makers that there was indeed a most serious nursing shortage, that the main reason for it was an inadequate number of graduating R.N.’s, and that the basic solution to it lay in spending millions of dollars on building a large number of new diploma schools of nursing. (We do not mean to imply, incidentally, that these conclusions and decisions were *necessarily* wrong; however, we will describe the decision-making process as far as we could deduce it and indicate those aspects of the process which were less than ideally rational.)

The sense of shortage in nursing is very definitely subjective and relative, though no less real a feeling because of that. Glaser points out, for example, that in both the United States and the United Kingdom there is a prevailing feeling of a shortage of nurses in spite of the fact that these countries possess two of the

world's most favourable ratios of graduate nurses to population, approximately 1:349 and 1:383 respectively in 1961.¹ By comparison, Canada (in which there is a similar feeling of shortage) in 1966 possessed a ratio of one practising graduate nurse for every 182 inhabitants. Ontario, which does not lag behind other provinces in the number of public outcries about shortages, was the most favoured of all provinces with a 1966 ratio of 1:136. (Other provincial ratios in 1966 were Saskatchewan — 1:173; British Columbia — 1:191; New Brunswick — 1:197; Prince Edward Island — 1:201; Manitoba — 1:206; Alberta — 1:208; Nova Scotia — 1:212; Quebec — 1:251; Newfoundland — 1:323.)²

The basically subjective nature of beliefs regarding nursing shortages can be illustrated also by noting the unreliability of much of the data cited above dealing with nurse-population ratios. For example, the figures mentioned by Glaser on ratios in the United Kingdom and the United States for 1961 (1:383 and 1:349 respectively) are considerably different from those cited in the Hall Commission *Report on Medical Services in Canada*, which cites a ratio of 1:471 for England and Wales and 1:294 for the U.S.A.³ Glaser cites the sources of his figures as the American Nurses' Association publication, *Facts About Nursing*, 1961 (p. 9) for the U.S. data and the 1961 *Report of Member Associations of the International Council of Nurses* (pp. 94-96) for the U.K. data. The Hall Commission cites publications of the World Health Organization as the source of its data. Which sources are the most accurate? Why do such wide discrepancies exist? Nobody we consulted seems to know for certain. Again, in looking at the Canadian data only, the Hall report mentions a ratio of 1:255 for the country as a whole and cites the Canadian Nurses' Association as the source for this figure. Present members of the CNA research unit say they were not gathering national statistics at the time the Hall report was compiled and are uncertain as to where the original data used in calculating this ratio were found and what assumptions were made in deciding who to include. The CNA-produced ratio for 1966 was 1:182 — considerably lower than the Hall Commission figure for the earlier period. This may be primarily because the number of nurses has increased relatively faster than the population or because of differing assumptions on who to count or not count as an R.N.

The major reason for these many and confusing discrepancies is probably the different bases for counting R.N.'s. Does one include all R.N.'s or only those who are active and practising? What about categories for nurses who choose to maintain a "non-practising" registration with some provincial nurses' associations? What

¹William A. Glaser, "Nursing Leadership and Policy: Some Cross-National Comparisons", in Fred Davis, *op. cit.*, pp. 1-59.

²Statistics were gathered at the time of writing from unpublished data provided by the Research Unit of the Canadian Nurses' Association; these have since been published by the CNA in a booklet entitled *Countdown 1967*.

³Hall Commission, *Report on Medical Services in Canada*, Vol. 1. Queen's Printer, Ottawa, 1964, Tables 714 and 716, pp. 265, 267.

about R.N.A.'s and graduate but non-registered nurses? Insofar as the statisticians at different points in time and in different provinces or countries make different decisions on these questions, the nurse-population ratios are not comparable.

Finally one may even wish to question the value of the ratios as guidelines for any policy decision in that, given that only figures on registered nurses are used, the number who register can be greatly affected by the cost of registration. Considering the case of differences in nurse population ratios from province to province, for example, Ontario appears to be the best endowed with R.N.'s, its ratio of 1:136 being substantially lower than that of any other province. But it is true also that Ontario has by far the lowest registration fee in Canada; hence it is quite possible that many R.N.'s who have no intention of practising maintain their registration in Ontario, while their counterparts in other provinces feel it would not be worth it.

If we agree, now, that judgements about the severity of nursing shortages are very subjective, the next interesting question is what leads people to arrive at one subjective conclusion as opposed to another? Glaser has some ideas on this.⁴ One condition is the rate of development of medical science, which generates more and more complex technical and administrative work. When this is coupled with an increasing *availability* of medical services to the population, it leads to more nurses being drawn into administration and teaching, leaving fewer to carry out the increasing amount of bedside nursing required. The feeling of shortage is thus a result of, not a decreasing number of nurses, but the way their services are utilized when the demand for simple bedside care is increasing.

Another factor is the increasing rationalization of nursing and other paramedical occupations; this is manifested in the development within hospitals of statistical ratios, proportions and formulae which variously represent the ideal number of nurses needed for what is felt to be optimum service. The clarity and concreteness of the figures resulting from the subtraction of actual nurses available from numbers ideally "needed" as represented by the figures creates a stronger feeling of shortage than in the days when needs were not so rationally calculated.

The Facts on Supply and Demand

Measures of Overall Shortage

Budgeted Positions Minus Numbers Employed

Our naive first assumption regarding what would both define and measure the nature and extent of a nursing shortage was that we would simply obtain, from the OHSC and the Department of Health, information on the number of budgeted *positions* for the various classes of nurse in hospitals and public health agencies (the two major employers of nurses) and then subtract from this the number of

⁴William A. Glaser, *op. cit.*

nurses who had been actually employed to fill these positions. The extent of the difference between budgeted positions and actual staff, we confidently felt, would be a fairly good indicator of how far below the desired quantity standard the current situation was. Furthermore, we fully expected to find these figures broken down by region, by hospital size, and by hospital type (general, mental, chronic care and rehabilitation, and so on), and thereby specify where the shortages were most acute, if anywhere. Future shortages would have been estimated by simply substituting projected needs and projected supplies for the actual figures.

Even had we been able to find such information, the result would have been slightly misleading, in that it implies acceptance of present ways of utilizing nursing personnel on the demand side — that is, that the present number and type-mix of nurses needed and the way their time is utilized is the ideal number and mix, or the ideal utilization. Such, of course, is not the case. As indicated in Chapter 2, it is entirely possible that demand could be reduced, at least for certain classes of nursing personnel in hospitals and perhaps public health agencies, through more effective utilization patterns.

In fact, though, we were quite unable to use our simple little method for identifying the nature and extent of the nursing shortage in hospitals (we had a little better luck for public health agencies).

The reasons why the "budgeted positions minus actual employed" method was not usable were explained to us by various officials at the OHSC. All hospitals must annually submit to the OHSC form HS-1, which is used as the basis for establishing the hospital budget and is supposed to include numbers of each type of personnel needed and previously approved by the OHSC. According to our informants in the Commission, however, it is still possible for hospitals to claim on the form an inflated number of positions.

In addition, some hospitals do not always follow the specified definitions of the various classes of nurse, such as graduate nurse and qualified nursing assistant, thus making it difficult to compute totals for all hospitals.

Then there is the problem of hospitals which request additional staff after the budget has been approved. Evidence of whether or not such requests are approved, we were told, is not always clear in the records nor is it extracted from the individual OHSC records on each hospital.

The original estimate of positions needed is based partly on the hospital's records of the number of patient-days for the year. A point made by one of our OHSC informants was that, if there are beds available, many hospitals have patients in the hospital for more days than may be necessary. This situation commonly occurs on weekends, for example, when a doctor may admit a patient on Friday evening when the operation the patient requires will not be performed

until Monday. Such patients may require little or no care, or may even go back home for part of Saturday and Sunday, yet their official presence is used in calculating the number of staff needed.

Another problem is that the hospitals report their actual staff employed for a specific day, December 31, of each year. This figure reflects not only those positions which the hospitals have been unable to fill for some time, but also those positions which are only very temporarily vacant. Thus there may be no real difficulty obtaining a replacement for someone who left in December, but the replacement may not officially start work until January 1. In other words, the reported figures for a given point in time may not necessarily be a reflection of the "true" shortage of staff. A better estimate might be provided if hospitals were required to report positions which have been vacant for more than a month. However, such information is not required on the annual report.

Finally, the factor which most upsets the validity of the "budgeted positions" figures is the tendency of many hospitals to adjust the ratio of professional to non-professional personnel within the constraint of the total budgeted salary figure for the nursing department. We have already seen in Chapter 2 how difficult it is in many cases to make a clear distinction between R.N. work and R.N.A. work. As a result, some hospitals may replace two R.N.A.'s with one or one and one-half R.N.'s, if they are available, or vice versa.

At any rate, because of complicating factors such as these, and because of a shortage of personnel within the OHSC, the Commission has not calculated nursing demand and supply in what we feel would be the most simple and direct method.

Hours of Care per Day

How, then, have nursing "shortages" actually been estimated? Two long-standing standard measures of the quantity and, to some extent, quality of nursing care provided in hospitals in the United States and Canada are the "hours of care per patient per day" statistic and the ratio of "professional" to "non-professional" nursing staff. The "hours of care" figure is arrived at by dividing the total number of hours worked by all staff in a nursing unit by the number of patients in the unit. For example, in a surgical unit with an average patient census of twenty-nine and nursing staff of fourteen (all types) working eight hours per day, the hours of care per patient would be

$$14 \times 8 \text{ hours} = \frac{112}{29} = 3.8 \text{ hours}$$

If one can decide on what is an acceptable standard in terms of hours of care and professional:non-professional ratio, it is possible to infer the nature and extent of the nursing shortage in terms of how far the actual figures fall below the standards.

The first question, then, is whether there is an agreed upon standard. As with so many other questions in nursing, the answer seems to be yes and no.

For the first few years of the existence of the OHSC, the Commission's nursing consultants lacked first-hand experience in evaluating the needs and actual conditions of the province's hospitals. As an initial guideline in assessing the hospital's budget submissions for nursing staff, therefore, they made use of the findings of a rather widely accepted United States study on desirable numbers and "mixes" of staff.⁵ This study was carried out in 1947 in one children's hospital and twenty-one general hospitals. It concluded that the average number of nursing hours needed per patient per twenty-four-hour day is 3.8, with 76 per cent of those hours to be given by professional nurses and the remainder by non-professionals. In later years, with the advent of more, better trained (and better accepted) nursing assistants, and with increasing shortages of R.N.'s, the "acceptable" professional:non-professional ratio became modified in "standards" manuals. The OHSC nursing consultants settled on 3.2 to 3.4 hours of care per patient and a 60:40 professional:non-professional ratio as rough guidelines to follow in their initial years of operation. (In the United States, however, a 40:60 professional:non-professional ratio is accepted as a not entirely intolerable standard to work with.)

OHSC consultants and all other nursing officials spoken to emphasize that there is no single acceptable standard of quantity or quality of care in a given nursing unit. They quite correctly point out that the hours of care needed are very much a function of the nature and severity of the patient's illness, the calibre of the staff, the layout and design of the unit, and the "up-to-dateness" of the unit in terms of its equipment and the calibre of management and management systems. The same factors affect decisions on what is an acceptable professional:non-professional ratio. In spite of all this, the consultants recognize that to form *overall* policy decisions in the area of nursing needs, a general picture of the province-wide situation must be developed and very general standards must be formulated. When asked what standards to apply on a province-wide basis, they will concede that somewhere around 3.5 hours of care and the 60:40 ratio form rough but adequate benchmarks.

With this in mind, it is worth looking at two statistical studies carried out by the Statistical Research Division of the OHSC on hours of care and who gives them in nursing for the years 1964, 1965 and 1966. These studies are included in their entirety as Appendix II to this report. Table 9 summarizes some of their highlights. It can be seen that in the majority of hospitals in the province, the overall hours of care per day provided to patients are well above the 3.5 standard, even when one makes allowance for the 15 per cent or so of "hours of care"

⁵Described in the "Hospital Nursing Service Manual" published by the American Hospital Association and National League of Nurses, 1950.

TABLE 9
Nursing Hours of Care per Day and Distribution of Care Between
Nursing Department Personnel in Ontario Hospitals, 1964 - 1966

	Hours of Care per Day			Percentage of Care Provided by Grad. Nurses (Reg. and Non-Reg.) ¹			Percentage of Care Provided by Qualified Nursing Assistant ¹			Percentage of Care Provided by Orderlies (All Levels) ¹			Percentage of Care Provided by Other Nursing Dept. Personnel		
	1964	1965	1966 (+ or -) 1964-1966	1964	1965	1966 (+ or -) 1964-1966	1964	1965	1966 (+ or -) 1964-1966	1964	1965	1966 (+ or -) 1964-1966	1964	1965	1966 (+ or -) 1964-1966
GENERAL HOSPITALS															
Group A (Teaching)	6.4	6.6	6.9 + .5	53	53	54 + 1	13	13	13 0	9	9	9 0	24	25	25 + 1
Groups B and C (100 + beds)	6.1	6.2	6.3 + .2	52	54	55 + 2	18	19	19 + 1	6	5	5 - 1	24	22	21 - 3
Groups B and C (1-99 beds)	5.6	5.7	5.9 + .3	51	52	53 + 2	24.5	25	24 0	4	4	4 0	21	19	19 - 2
Group D (4-22 beds)	5.4	5.7	5.8 + .4	60	68	63 + 3	30	29	30 0	2	3	7 + 5	8	0	0 - 8
CONVALESCENT	3.9	3.9	4.0 + .1	38	37	41 + 3	20	18	17 - 3	4	13	11 - 3	29	32	30 + 1
CHRONIC	3.9	4.0	4.2 + .3	24	26	27 + 3	15	15	13 - 2	10	10	9 - 1	50	50	50 0
TOTAL: ALL HOSPITALS	5.8	6.0	6.2 + .4	50	51	52 + 2	17	17	17 0	7	7	7 0	25	25	24 - 1

¹Rounded to nearest whole number.

which, in fact, consist of the time of administrative and instructional staff who do not tend patients directly. Only the hospitals for chronically ill and convalescent patients get close to the 3.5 hours of care — presumably, at least in part, because the nature and severity of illness of most of the patients in these hospitals is such that they require less care. Also, the number of hours of care offered appears to be slowly but steadily *increasing* over the years — something that would be difficult to achieve if there were any general and severe shortage of nursing staff.

Looking at the proportion of care provided by professional and various non-professional personnel, it is apparent that the “60-40” standard has been met in only the small outpost hospitals (Group D) in the province. In the major general hospitals the proportion of professional care comes within 5 to 7 percentage points of 60 per cent, but it is far below average in the chronic and convalescent hospitals, again partly because the patients there *require* less professional care. Looking at the trend over time, if there has been a growing nursing shortage, we should see the proportions of care by graduate nurses declining and the proportions for various non-professional groups rising. As can be seen in Table 9, the changes on the whole between 1964 and 1966 are slight but for the most part show *increasing* amounts of care being given by graduate nurses, and *decreasing* amounts by non-professionals of all kinds. This trend is the most pronounced in the chronic and convalescent hospitals — the two types of hospital which have always found it the most difficult to attract R.N.’s due to the routine nature of most of the care given.

Obviously, one must be extremely cautious in drawing firm conclusions from such general and rather indirect statistics as these. Whether one feels there is a shortage of nurses depends very much on the standards one adopts. Even at that the figures permit no inference about how many of the hours of patient care per day actually are spent in giving *direct* patient care, nor is there any indication of the *quality* of care given by any of the categories of personnel. It would seem that, at most, we can conclude that there is little sign of any increasing shortage of professional nurses.⁶

This conclusion is confirmed if we look simply at the numbers of staff in the various categories over the past few years to see how much they have been increasing. Table 10 presents OHSC data on this for the years 1964 to 1966 and their projections for 1967 and 1968 (actual 1967 figures are not available at the time of writing). Evidently none of the nursing staff categories tabulated has suffered an absolute decline. Furthermore, the increase in graduate nurses of 14.6 per cent

⁶It should be noted incidentally that the apparent *decreasing* amount of care being provided by non-professional staff *could* be interpreted to indicate increasing shortages in these classes of staff coupled with an increasing tendency to give graduate nurses work which could be done adequately by others. In fact, we know of no responsible expert who would actually draw such an inference.

TABLE 10
Full-time Equivalent Staff by Classification for Years 1964 to 1966 and Projected for Years 1967 and 1968
Also Percentage Increases or Decreases for Years 1965/1964 and 1966/1965
Public, Active, Chronic, Convalescent and Psychiatric Hospitals
Based on 1964, 1965 and 1966 Annual Return of Hospitals Form HS-1

[illegible]

between 1964 and 1966 is considerably greater than the increase in R.N.A.'s (9.1 per cent), orderlies (4.8 per cent) and other nursing department personnel, such as ward aides, clerks, and so on (5 per cent).

Having taken a general look at the recent past, let us see what information there is on the future.

The Nurse:Bed Ratio

Similar in concept to the hours of care per day measurement for calculating hospital nursing shortages is the calculation of a ratio of practising nurses to the number of hospital beds. In fact, it was a study of this type carried out in 1965 by Miss Naomi Grigg, Director of Statistical Research in the OHSC, that formed the primary basis of much of the thinking and action concerning nursing education and what to do about it since that time. A copy of this study is included as Appendix III to this report. A nursing surplus is projected of some 12,500 registered nurses by 1970, *if* one assumes a .43 bed to nurse ratio; a graduation rate of 5,000 per year; an even balance of immigration and emigration; a constant rate in terms of the proportion of R.N.'s who do not work in hospitals and R.N.'s who do not work at all; and, finally, no decline in hours of service performed by students.

The trouble is, of course, that these assumptions can be questioned. It seems unlikely, for example, that there will be 5,000 graduates per year by 1970. In spite of the efforts of the Department of Health and others, the figure will more likely be in the vicinity of 3,500. Also, the balance of emigration and immigration is almost impossible to predict. For example, in Miss Grigg's OHSC study, a net increase of immigration over emigration of anywhere from 98 to 1,116 is shown for the years 1961-1964. Yet federal Department of Labour statistics for the years 1956-1960 show net *losses* of between 130 and 231 for every year except one.⁷ Perhaps the assumption of equilibrium for the future is about as reasonable as one could make.

The assumption of no increase in proportion of non-working nurses also is doubtful in the light of belated but strenuous efforts to attract more retired nurses back to work by means of active recruiting drives and enlarged and more frequent refresher courses. In addition, the trend for the two years 1965-1966 indicates increasing numbers of retired nurses re-entering the labour force (see p. 92). Finally, current inflationary tendencies in the economy may further increase the appeal of work to married and retired nurses feeling the need for extra cash.

The assumptions of no decline of hours of service given by students up to 1970 seems reasonable in spite of the tendency towards two-year training pro-

⁷See Bulletin No. 11, October 1961, Economics and Research Branch, Department of Labour, Ottawa.

grams with no time allotted for service. It is unlikely that these will have replaced the current "two plus one" and three-year programs to any appreciable extent by 1970.

How about *after* 1970? We could find no one willing to predict in any detail the amount or rate of growth in hospital bed rates after 1970, although several officials in the OHSC felt it would certainly be considerably below the rate of growth expected between mid-1967 and 1970. These same men also expressed their private belief that *if* the rate of 5,000 nursing graduates a year were achieved by 1970 or soon after, and maintained at that rate, there certainly *would* be a high probability of a real surplus of professional nurses by today's standards.

Obviously, if one defines the acceptable nurse:bed ratio as something greater than .43, then "surpluses" are quickly reduced or changed to shortages, as Miss Grigg's study shows. What is the optimum ratio? Much depends on how many of the hospital nurses actually work directly at the beds rather than performing other activities. It is all very well to say there are about 2.3 beds per nurse, but what does this mean in terms of the quantity and quality of care actually given to patients? In practice, it seems to us from our visits that the .43 ratio means that the average *staff* nurse in a hospital has the equivalent of seven to ten patients of average sickness to look after (fewer for very sick patients and more for mildly sick people). Is this too many or too few? In the end it depends on the ability of the nurse, the equanimity of her patients, and the amount of non-nursing work she is required to do.⁸

In concluding this review of province-wide studies of future supply and demand, it is perhaps worthwhile to contrast the conclusions with those of a recently reported U.S. study.⁹ This study concludes that between 1965 and 1975 the growth in demand will exceed the growth of supply by 100,000 nurses. The study does not provide details for the calculation of demand, but it is apparent that a considerably higher growth rate in the demand for health services is predicted as compared to the Ontario growth rate. While one cannot be certain, this may be due to predicted changes in conditions governing the use of hospitals; conditions which already exist in Ontario, such as larger numbers of hospital beds, and more prepaid hospital and medical insurance. If this is so, it would explain the large proportional discrepancy between the U.S. and Ontario studies.

⁸As one illustration of the ambiguities inherent in deciding what a desirable nursing supply should be, it is interesting to contrast one of the conclusions of Miss Grigg's OHSC study and that of the Province of Manitoba's *Report of the Minister of Health's Committee on the Supply of Nurses*, November 1966. In the first worksheet (see Appendix III) of the OHSC study, the population of Ontario for 1970 is projected as 7,394,000 and the total estimated number of registered nurses required to provide a .43 nurse:bed ratio as 57,228. This is a ratio of about one nurse per 127 of population. The Manitoba Report (Recommendation 7) favours a minimum acceptable goal of 450 nurses per 100,000 of population by 1970 or one nurse for every 222 people. Which goal should be adopted?

⁹See Report of the National Advisory Commission on Health Manpower, Vol. 1, U.S. Government Printing Office, Washington, D.C., November 1967, pp. 22-23.

Impressions Formed from Field Visits

So far our efforts to describe clearly the general amount of shortage or surplus in nursing have not been fruitful because of the great difficulties of measurement and paucity of usable data. If anything, they indicate that there has not been a serious shortage so far, and that there may not even be a very severe one in the future. Before we look more closely at the problem in terms of the various classes of nurse and other employing agencies, it might be worthwhile to insert here our own general impressions of the nursing shortage as gleaned from nursing directors, and others in the hospitals and public health agencies visited during the summer of 1967. These impressions were formed by asking anyone likely to have experience in the matter whether they needed more nurses of various kinds; whether or not their organization experienced shortages; and if so, where, when and what kind. Clearly there were no numerical data to be obtained by such an approach.

On this basis, unquantitative though it was, we gathered the following information. The only ones to tell us they experienced continuing and noticeable shortages were officials in chronic care hospitals and one or two hospitals in remote rural areas. We were told by others that there is also a chronic nursing shortage in mental hospitals. The majority of officials interviewed said there was no *lasting* shortage for them except for trained or trainable orderlies in the large metropolitan areas. On the other hand, virtually all hospitals claimed they suffered occasional short-term shortages and shortages during the summer months. For most, these summer shortages were severe, but a few had worked out explicit plans to mitigate the summer exodus (for example, by using university nursing students and paying unofficial overtime).

A few people spoken to said the severity of the summer shortage was more apparent than real. While not denying that some of the shortage was quite genuine, they did point out that the hospital's patient census commonly falls off in the summer, as physicians controlling patients whose hospitalization is elective often keep them out of hospital while they, the physicians, take vacations. Thus, although budgeted establishments for nurses remain the same in summer, in fact fewer nurses are needed.

We could find no explanation for an anomaly discovered in at least three urban centres visited: that of one general hospital experiencing the phenomenon of having to turn nursing applicants away while another hospital nearby seemed to have real difficulty finding enough staff. The most we could adduce from talking to nurses in the area was that the latter hospitals had reputations as poor places to work and were avoided if at all possible. Once such a reputation is formed it can quickly become a self-fulfilling prophecy, as the remaining staff must assume greater and greater amounts of responsibility in order to keep going under increasingly difficult conditions.

Although we found that true shortages lasting more than a month were rare, most hospitals we visited suffered more or less continuously from high nursing staff turnover. They usually found people to replace the leavers, but the impression we obtained was one of "always advertising for nurses"; this may enhance the *feeling* of shortage among the hospitals' administrative officers. This problem of mobility will be discussed in more detail later.

Regarding future conditions, we were led to believe that there might well be a genuine shortage of nurses in some specific geographical areas between 1967 and 1971. This would be due to the completion of a fairly large number of planned additions to existing hospitals and new hospitals. With all these new beds opening in a relatively short period of time, it might indeed become difficult to find staff of all kinds. Metropolitan Toronto, in particular, seems likely to experience a major expansion in hospital beds in the next few years. After the period of great expansion, about 1972, apparently there will be considerable levelling out of construction and slowing down of growth, thus mitigating the previous shortage or possibly even resulting in a surplus.

Supply and Demand in Non-Hospital Settings

Although the objective of this section is to convey a picture of present and future supply of and demand for nursing as a whole in Ontario, the emphasis so far has been on hospitals and particularly graduate nursing in hospitals. This is because of the tendency for provincial statistics to be accumulated on the basis of groups of employing agencies rather than on a profession-wide basis. The OHSC gathers figures for hospitals, and the Department of Health gathers them (on an irregular basis) for public health agencies. No one is responsible for gathering them from other employers, such as industries, nursing homes or private duty registries. Professional nurses' associations gather figures on overall supply but nothing on the demand side; and, at that, they concentrate on registered nurses to the relative exclusion of non-registered graduates, R.N.A.'s, orderlies and other nursing personnel. In spite of these problems, let us examine what additional information we have.

In the case of public health, we have the report of a fairly detailed special study of nursing manpower in Ontario for 1966 which tells a lot about the nature and distribution of public health nursing personnel. Unfortunately it does not try to estimate demand either in the past or for the future. All we have is the one statement that in the 704 public health agencies of various types responding to the survey, employing a total of 3,015 registered nurses, there were seventy-six vacancies reported as of November 30, 1966. As with other single-point-in-time figures, this one includes both temporary vacancies caused by nurses being in transit from one job to another and long-term vacancies caused by a shortage of staff. Is this shortage of public health nurses greater or less than in the past? Is it going to get larger or smaller in the future? We could get no detailed figures or predictions on these questions. Officials in public health agencies and the

Department of Health assured us that there was a shortage of trained public health nurses, particularly for highly qualified senior level types, and that it would be getting worse as the various agencies expanded in the future. The severity of the alleged shortage in public health could not be ascertained. We suspect, however, that it cannot be extreme; if it were, one would expect to see, for example, more rapid action in resolving such conflicts as that concerning what non-public health specialist R.N.'s should be allowed to do in public health agencies. One might also expect to see a little more publicity of the problem if there were a severe shortage. (It should be noted, however, that public health employees do not have an employers' association to help them identify and publicize their problems, as is the case with hospitals; so that one cannot really judge by the relative amount of public outcry from the two groups of employers.)

As for answers to the demand-supply question among other employers of nurses, the information available is even more scanty. In fact, reliable province-wide estimates of demand are non-existent. Only supply figures exist. These are considered in the next section.

Facts on the Supply of Nursing Personnel

Overall Supply

One can perhaps understand why there are few large-scale descriptive studies in which both supply and demand are treated together: the measures of current and future demand are so ambiguous. One *would* expect, however, that there would be an abundance of data on supply alone. At the very least, in the case of the *registered* nursing classifications, one confidently could expect to find complete tables and charts showing the trends in numbers of registrants over the years, the breakdowns by region, by numbers employed, and by type of employment, and so on. After all, such data are submitted annually by all nurses in the country every year they register. But our expectations of detailed statistics were disappointed again. Nation-wide comparisons of nursing supply were begun only in 1965 with the creation of a Research Unit in the Canadian Nurses' Association and the standardization of report forms from province to province. Even within Ontario, though tabulations have been kept of the total number of registrants over the years, there was no breakdown of the figures until the Canadian Nurses' Association created a research unit to start doing it. The situation is even more gloomy when one looks at groups in nursing other than R.N.'s. The total number of R.N.A.'s in Ontario over time is recorded, but no national comparisons and no breakdowns are made except for 1966 Ontario registrants. There are, of course, no figures on the total number of people *able* to fill other nursing positions. For those employed in non-registered nursing positions, there are totals only for full-time and part-time, by type of hospital and by province for 1964 and 1965.

Looking first at the country as a whole, Table 11 shows the total number of R.N.'s in Canada in 1965 and 1966, broken down according to whether or not

TABLE 11
Registered Nurses in Canada by Status of Employment, 1965-1966

	1965	1966	Percentage of Change (+ or -) 1965-1966 ¹
Total	98,190	112,866	+ 15
Employed in nursing:			
Full time	52,130	61,466	+ 18
Part time	17,226	21,051	+ 22
Not employed in nursing:	23,304	24,638	+ 6
Status not known	5,530	5,711	
Percentage of total R.N.'s definitely not employed in nursing	23% ¹	21.8%	- 1.2

¹Percentages rounded to nearest whole number.

SOURCE: Research Unit, Canadian Nurses' Association.

TABLE 12
Registered Nurses and Registered Nursing Assistants, Ontario, 1963-1967

	1963	1964		1965		1966		1967	
No.		% Inc. over No. prev. yr.		% Annual No. Inc.		% Annual No. Inc.		% Annual No. Inc.	
R.N.	43,991	46,737	6.2	48,922	4.7	50,798	3.8	54,513	7.3
R.N.A.	8,183	9,541	16.6	10,959	14.9	12,223	11.5	14,011	14.6

Ratio

R.N.:

R.N.A.

(in round 85:15 83:17 82:18 81:19 80:20
numbers)

SOURCE: Records of Ontario College of Nurses.

they were working as nurses. Tables 12 and 13 permit a comparison of the national picture with that for Ontario.

From Tables 11, 12 and 13, it can be seen that the number of both R.N.'s and R.N.A.'s has been growing constantly — though at a slightly irregular rate — since 1963, with R.N.A.'s increasing at a rate two or three times greater than R.N.'s and as a result forming an increasing proportion of the total registered nursing group.

TABLE 13
Registered Nurses by Status of Employment, Ontario, 1965-1966¹

	R.N.		R.N.A.
	1965 ²	1966 ³	1966
Total	44,963	50,721	12,223
Employed in nursing:			
Full time	19,971	24,921	9,430 (Full-time/
Part time	9,165	10,509	part-time status
			not known)
Not employed in nursing:	13,237	13,288	?
Status not known	2,590	2,003	?
Percentage of total R.N.'s and R.N.A.'s definitely not employed in nursing	29.4%	26.2%	22.8% (figure is based on number not employed <i>plus</i> status unknown — i.e., total registered minus total employed)

¹A comparison between years in this table is not possible since the data for 1965 exclude nurses registering for the first year (about 4,000 of them) and the data for 1966 include that year's new registrants.

²Figures are for renewals only and *exclude* new registrants in that year.

³Figures *include* new registrants for that year.

SOURCES: Research Unit, Canadian Nurses' Association and records of Ontario College of Nurses.

Also in both Canada as a whole and Ontario, at least between the years 1965 and 1966, the rate of growth in *employed* R.N.'s has far exceeded the increase in those not employed. Put another way, there is a decline in the number of nurses registered but not nursing, and Ontario exceeds the Canadian average in this regard.

It is worth taking special note of the fact that in 1966 there were 13,288 graduate nurses who went to the time and expense to register but who were not employed at the time they did so. Another 2,003 registered but did not say whether or not they were working. As an indicator of an unused potential of nursing resources, these figures on the one hand could be thought of as being exaggerated, since they include an unknown number of people who were only temporarily between jobs when they registered. On the other hand, they can be seen as heavily conservative because they omit untold numbers of graduate nurses

TABLE 14
Number of Orderlies and Other Nursing Personnel Employed in Ontario Hospitals, 1964, 1965

	GENERAL AND ALLIED SPECIAL HOSPITALS										T.B. SANATORIA		TOTAL					
	Public			Private			Federal		MENTAL HOSPITALS									
	Percentage of			Percentage of			Percentage of		Percentage of		Percentage of		Percentage of					
	1964	1965	Change	1964	1965	Change	1964	1965	Change	1964	1965	Change	1964	1965	Change			
Orderlies	2,473	2,485	+ .005	28	22	-21	710	694	-.02	not available		73	64	-12	3,284	3,265	-.006	
Other nursing personnel	9,236	9,478	+ .03	351	312	-11	145	253	+ 74	4,134	4,750	+15	160	154	+04	14,026	14,947	+ .066

SOURCE: Research Unit, Canadian Nurses' Association.

(and nursing assistants) still able to make a contribution, who have simply not bothered to maintain their registration because they know that they can automatically get reregistered by paying a nominal reinstatement fee whenever they want to return to work.

All in all, then, it appears that there may be more than 13,000 R.N.'s and perhaps 2,500 R.N.A.'s in the province who form a pool of potential nursing resources. Until recently, they have been largely ignored. There have been no studies designed to find out what it would take to attract them back to work, or how many of them would be able to function adequately if they did come back. Only since late 1967 has the newly formed Planning and Research Branch of the Department of Health been in a position to commence pilot studies in this area. No province-wide, government-sponsored programs have been set up to attract these people back into the labour market. A few refresher courses have been offered in the past to non-practising nurses by individual hospitals; but again, it was only in late 1967 that a coordinated, cooperative endeavour among various health agencies, plus the RNAO, the OHSC and the OHA in the Toronto area, was mounted to recruit and retrain retired R.N.'s on a significant scale.

Looking next at the non-registered classes of nursing personnel, Table 14 indicates their numbers in 1965-1966. While the total demand for nursing services increased over 1964-1965 due to increasing population and expanded hospital facilities (there was a 1.3 per cent increase in hospital beds in all Ontario hospitals between 1964 and 1965), the number of orderlies did not increase and the number of other nursing personnel increased at a slightly disproportionate rate (.06 per cent). This could mean that there is a shortage of orderlies and their work has had to be given to other nursing personnel; or it could mean a deliberate effort to change the nature of the orderlies' jobs so that fewer will be needed and hence fewer hired—and vice versa for other nursing personnel. Note, incidentally, the very great increase in these classes of nurse in federal hospitals (which usually have a high proportion of long-term care patients) and in mental hospitals. Such increases are consistent with our hypothesis that hospitals which are viewed by a majority of nurses as low status and unattractive have the greatest difficulty getting registered staff and hence have to employ more and more untrained staff.

Distribution of Supply by Employer

Table 15 shows where the R.N.'s and R.N.A.'s worked in 1965 and 1966 (for R.N.A.'s, only 1966 figures are available). Table 14 shows similar figures for the nursing classifications below R.N.A.

It can be seen from Table 15 that, contrary to the popular belief in some circles that nurses are deserting the hospitals in droves to enter other areas of nursing, this was certainly not the case between 1965 and 1966. On the other hand, among the next largest group of employers, public health agencies, there

TABLE 15

Proportions of Total Employed Registered Nurses and Registered Nursing Assistants in Various Fields of Employment, Ontario, 1965-1966

(Ns = 29,136 R.N.'s
9,430 R.N.A.'s)

Employing Agency	R.N.			R.N.A.
	1965 %	1966 %	Increase or Decrease %	1966 %
Hospital or other institution	72.5	76.9	+ 4.4	91.0
School of nursing	3.6	3.3	- 0.3	—
Private practice	5.9	4.8	- 1.1	2.1
Public health (other than school health)	6.1	5.9	- 0.2	1.2
School health	.9	.7	- 0.2	—
Occupational health	2.3	2.3	—	.4
Office (physician or dentist)	3.5	3.2	- 0.3	2.1
Nursing home	?	?	?	2.8
Other specified field	.7	.4	- .03	.4
Field not reported	4.5	2.5	- 2.0	—

SOURCE: Research Unit, Canadian Nurses' Association.

was a slight decrease in proportions of the total R.N. labour force in this work; in fact, all the fields of employment other than hospitals suffered a proportional decline.

If we look next at the absolute numbers in the various fields of employment (Table 16), we see that by this measure too the percentage increase in numbers employed in hospitals is greater than in all other areas, followed by occupational health and public health. Note, incidentally, how the proportionate increase in R.N.'s employed far exceeds the proportionate increase of 1.3 per cent in hospital beds throughout the province in that period.

Table 17 shows that general duty nursing and the lower level supervisory positions are the most common jobs for R.N.'s, but that the proportion of the total work force employed in them in 1965-1966 declined slightly in all but general duty nursing, where it increased considerably. The numbers in each type of position increased over the two years, with general duty nursing far outstripping the rest.

Distribution of Supply by Position Held

Table 17 shows the types of position working nurses held in Ontario in 1965 and 1966.

TABLE 16

**Numbers of R.N.'s and R.N.A.'s Classified by Field of Employment, Ontario
1965-1966**

Employing Agency	R.N.			R.N.A.
	1965	1966	Increase or Decrease %	1966
Hospital or other institution	21,122	27,250	+ 29	8,579
School of nursing	1,052	1,160	+ 10.3	—
Private practice	1,712	1,711	0	194
Public health (other than school health)	1,786	2,102	+ 17.7	112
School health	248	261	+ 5.2	—
Office (physician or dentist)	1,012	1,132	+ 11.8	200
Occupational health	686	817	+ 19.1	42
Nursing home	?	?	?	266
Other specified field	215	127	- 40.9	37
Field not reported	1,303	870	- 33.3	—

SOURCE: Research Unit, Canadian Nurses' Association.

Summary

While it is highly improper to claim a trend on the basis of data for only two years, on the basis of what is shown in Tables 11 to 17 inclusive it seems reasonable to assert that between 1965 and 1966, at least, there was certainly *not* a decline or even a merely modest increase in the supply of nurses. By whichever way we break the data, the increases seem to be substantial, particularly in the areas of rank-and-file nursing in hospitals where the need is alleged to be greatest. If it is possible to infer anything at all about shortage from rates of change in supply from year to year, it would be that there are not enough orderlies, nurse's aides and R.N.A.'s, and not enough R.N.'s in other than general duty hospital jobs, since the rates of increase in these areas are not nearly as large as they are for the general duty R.N. Of course such a generalization would have to be asserted most tentatively. The statement, however, is corroborated by the previously discussed data (shaky though it may be) and by our own impressions gained from interviews around the province.

Distribution of Supply by Qualifications and Some Significant Background Characteristics

Qualifications of nurses. What kind of educational preparation do working R.N.'s possess? Where do the nurses with the various preparations work, and what kind of jobs do they hold? These questions are answered in Tables 18, 19 and 20.

TABLE 17

**Registered Nurses Employed in Nursing Classified by Types of Position Held
Ontario, 1965-1966**

Position	1965		1966		Percentage of Increase or Decrease	
	Number	% of Total R.N. Work Force	Number	% of Total R.N. Work Force	In Numbers Employed In Position	In Proportion of Total Work Force In Position
Director or Asst. Director of Nursing	716	2.5	764	2.2	+ 6.7	- 0.3
Supervisor or Asst. Supervisor	2,121	7.3	2,335	6.6	+ 10.0	- 0.7
Instructor	1,092	3.7	1,236	3.5	+ 13.2	- 0.2
Head Nurse or Asst. Head Nurse	3,353	11.5	3,602	10.2	+ 7.4	- 1.3
General Duty or Staff Nurse	17,997	61.8	23,757	67.0	+ 32.0	+ 5.2
Other specified position	2,048	7.0	2,122	6.0	+ 3.1	- 1.0
Position not reported	1,809	6.2	1,614	4.5	- 10.7	- 1.7

SOURCE: Research Unit, Canadian Nurses' Association.

From Table 18 it can be seen that, although a substantially increasing number of nurses obtains preparation beyond the basic diploma training, between 1965 and 1966 little progress was made in attaining the ideal held by professional nursing association spokesmen of having 25 per cent of the total R.N. work force made up of nurses with university degrees.

Table 19 indicates that nurses with more than the basic diploma training tend to work for organizations other than hospitals, notably schools of nursing and public health agencies (where post-basic training is either mandatory or very strongly preferred). Insofar as the two years for which we have data indicate a trend, however, it is apparent that the hospitals are attracting larger proportions of those with post-basic training. This indication is contrary to the common belief that degree nurses are actually leaving hospital settings in large numbers.

TABLE 18
Highest Level of Educational Preparations, Employed R.N.'s, Ontario, 1965-1966

N (1965) = 29,136

N (1966) = 35,430

Highest Level of Educational Preparation	1965		1966		Percentage of Increase or Decrease	
	Number	Percentage of Total	Number	Percentage of Total	In Number Within Each Preparation	In Percentage of Total Work Force Within Each Preparation
Diploma	25,257	86.7	31,531	89.0	+ 24.8	+ 2.3
Some post-basic credits leading to Baccalaureate degree	2,592	8.9	2,118	6.0	- 18.3	- 2.9
Baccalaureate degree	1,064	3.6	1,615	4.6	+ 51.8	+ 1
Master's degree	124	.004	154	.004	+ 24.2	
Doctorate	4	— ¹	7	— ¹	+ 75	
Other specified preparation	2	— ¹		— ¹		
Preparation not reported	93	.003	5	— ¹		

¹Negligible proportion.

SOURCE: Research Unit, Canadian Nurses' Association.

TABLE 19

Proportions of All R.N.'s Employed in Nursing, Classified
by Field of Employment and Highest Level of Educational Preparation,
Ontario, 1965-1966

Field of Employment	Highest Level of Educational Preparation											
	Diploma		Some post- basic credits towards degree		Bacca- laureate Degree		Master's Degree		Doctorate			
	1965	1966	1965	1966	1965	1966	1965	1966	1965	1966		
	%	%	%	%	%	%	%	%	%	%		
Hospital or other institution	76.6	80.0	49.3	55.9	40.0	48.8	21.0	27.9	—	—	28.6	
School of Nursing	1.5	1.5	13.1	11.9	25.0	21.8	50.0	50.0	75.0	75.0	57.1	
Private practice	6.3	5.2	2.8	2.5	1.9	1.7	.8	.7	—	—	14.3	
Public health (other than school)	3.3	4.0	26.3	22.9	23.3	21.6	12.1	11.0	—	—	—	
School health	.7	.7	1.5	.8	2.6	2.3	.8	1.3	—	—	—	
Occupational health	2.4	2.4	2.6	2.1	1.7	1.2	1.6	1.3	—	—	—	
Office (physician or dentist)	3.8	3.4	1.3	1.9	1.0	.6	—	—	—	—	—	
Other specified field	.5	.2	1.1	.6	3.1	1.7	12.1	7.8	25.0	25.0	—	
Not reported	4.9	2.6	2.0	1.4	1.4	.3	1.6	—	—	—	—	
N =	25,257	31,531	2,592	2,118	1,064	1,615	124	154	4	7		

SOURCE: Research Unit, Canadian Nurses' Association.

TABLE 20
Proportions of All R.N.'s Employed in Nursing, Classified by Type of Position Held
and Highest Level of Educational Preparation, Ontario, 1965-1966

Type of Position	Highest Level of Educational Preparation											
	Diploma		Some post-basic credits towards degree		Baccalaureate Degree		Master's Degree		Doctorate			
	1965	1966	1965	1966	1965	1966	1965	1966	1965	1966	1965	1966
	%	%	%	%	%	%	%	%	%	%	%	%
Director or Assistant	1.7	1.4	5.7	5.3	9.6	9.1	33.1	31.2	50.0	42.8	—	—
Supervisor or Assistant	6.8	6.2	11.3	11.8	8.6	8.4	8.9	5.8	—	—	—	—
Instructor	1.6	1.7	14.5	14.0	24.2	21.8	34.7	37.7	25.0	28.6	—	—
Head Nurse or Assistant	11.7	10.5	12.4	10.4	6.7	5.2	—	—	—	—	—	—
General Duty or Staff Nurse	64.4	69.2	48.4	52.5	39.9	49.5	3.2	7.1	—	14.3	—	—
Other specified position	7.1	6.1	4.8	4.2	7.6	5.1	16.9	17.5	25.0	14.3	—	—
Position not reported	6.7	4.9	2.9	1.8	3.4	.9	3.2	.7	—	—	—	—
N =	25,257	31,531	2,592	2,118	1,064	1,615	124	154	4	7	—	—

SOURCE: Research Unit, Canadian Nurses' Association.

Table 20 substantiates the expectation that the more education a nurse gets, the higher the level of position she will hold. Note, however, that among degree nurses the majority still work as general duty nurses, and that the proportion at this level is increasing rather than decreasing. This may be accounted for by the fact that the increases in degree nurses are caused by recent graduates from university schools, many of whom quite naturally start in a non-supervisory position in hospitals or public health agencies.

Background characteristics. Some of the discussion about the supply of nurses revolves around certain background characteristics they possess. It is sometimes said, for example, that there are too many or too few immigrants or married women, or that there are not enough men in the field.

With regard to the question of the number of immigrants in the nursing force in the province, there are no statistical data available other than the broadest sort. The Canadian Nurses' Association, for example, states that in 1966, 2,855 qualified nurses entered Canada and approximately 2,000 emigrated from Canada. But what proportion of employed R.N.'s in Ontario were trained outside the province or the country, and what the trend in this matter is, or where immigrants mainly come from, we could not find out.

Looking at marital status, according to the CNA Research Unit, of the 35,430 R.N.'s employed in nursing in Ontario in 1966, married women made up 55.5 per cent. They made up 40.8 per cent of those R.N.'s employed *full time* in nursing and 90.5 per cent of those employed part time. They also form the bulk of those *not* employed in nursing — 87.5 per cent. Between 1965 and 1966 the proportion of married *full-time* nurses declined almost 4 per cent over the year, the percentage of part-time marrieds rose one per cent, and the percentage of non-working marrieds declined but only by 0.6 per cent. Figures available for employed R.N.A.'s in 1966 show that 50.2 per cent of them were married ($N = 9,284$).

The number of men employed in nursing in Ontario is still extremely small — 183 male R.N.'s in 1965 and 261 in 1966. They are increasing at a faster rate than nurses in general but not enough to make any appreciable contribution to overall supply. Male R.N.A.'s in 1966 totalled 146 and made up 1.6 per cent of the nurses in this classification.

Turnover in Nursing

No doubt part of the reason that hospital administrators and others feel there is a severe nursing shortage is that they are always looking for nurses to replace the large proportion who quit them after a relatively short period in their employ. That most of the vacancies so created are filled relatively quickly (except in summer) seems not to have as great a psychological impact as the quitting.

It is worth looking at turnover and examining its extent in nursing, not only because it represents a pseudo-shortage, but more importantly because it can be a problem in its own right. There seems little question that a nursing unit staffed primarily by newcomers to the unit or the hospital (even though they have previous experience elsewhere) will not function as smoothly and effectively as one staffed by old hands who know each other and the way the unit and the hospital work. The time taken becoming familiar with a new situation invariably detracts from the quantity and quality of service provided.

It would be useful in analyzing turnover to know how many nurses, when they quit, actually drop out of the Ontario nursing labour market altogether because of marriage, childbirth, acceptance of non-nursing employment, or emigration. Such figures, however, are among the dozens of potentially useful data on supply and demand in nursing which are *not* tabulated, even though they could be, at least for R.N.'s and R.N.A.'s.

All we *are* able to look at is the amount of turnover in hospitals for the various classes of nursing personnel. Although the information is available on the standard hospital report forms submitted to the OHSC, the Commission itself does not tabulate these rates.

One comparative study of turnover has been carried out recently by the Research Unit of the Canadian Nurses' Association, using unpublished data for

TABLE 21
Mean Turnover Rate of Full-time Graduate Nurses — General Duty,
by Type of Hospital and Province, Canada, 1965

Province	Total	Type of hospital		
		Public ¹	Private	Federal
Canada	60.20	61.29	50.59	45.90
Newfoundland	97.92	101.28	—	.00
Prince Edward Island	55.97	55.97	—	—
Nova Scotia	63.26	66.46	—	26.60
New Brunswick	46.96	48.94	—	21.48
Quebec	50.64	52.00	37.76	35.29
Ontario	57.30	57.74	66.83	40.86
Manitoba	69.02	71.00	52.83	55.11
Saskatchewan	73.07	73.00	—	78.26
Alberta	86.30	87.14	—	76.96
British Columbia	58.87	60.64	56.41	44.03
Yukon	57.53	12.50	—	70.17
North West Territories	58.20	45.61	50.00	68.49

¹Includes both general and allied special hospitals.

SOURCE: Unpublished data from the Dominion Bureau of Statistics made available to the Research Unit, Canadian Nurses' Association, 1967.

TABLE 22
Mean Turnover Rate of Full-Time Qualified Nursing Assistants,
by Type of Hospital and Province, Canada, 1965

Province	Total	Type of hospital		
		Public ¹	Private	Federal
Canada	43.46	43.28	41.76	49.10
Newfoundland	55.67	57.57	—	.00
Prince Edward Island	25.39	25.39	—	—
Nova Scotia	33.42	37.02	—	5.09
New Brunswick	35.64	35.60	—	37.50
Quebec	35.39	34.76	39.22	70.73
Ontario	39.19	38.87	42.30	46.88
Manitoba	51.65	49.96	86.95	89.79
Saskatchewan	61.36	61.84	—	22.22
Alberta	62.99	63.41	—	57.02
British Columbia	54.88	54.62	—	58.82
Yukon	102.22	—	—	102.22
North West Territories	84.33	140.00	—	52.83

¹Includes both general and allied special hospitals.

SOURCE: Unpublished data from the Dominion Bureau of Statistics made available to the Research Unit, Canadian Nurses' Association, 1967.

TABLE 23
Mean Turnover Rate of Orderlies, by Type of Hospital and
Province, Canada, 1965

Province	Total	Type of hospital		
		Public ¹	Private	Federal
Canada	42.31	46.81	76.43	25.18
Newfoundland	42.18	42.18	—	—
Prince Edward Island	20.00	20.00	—	—
Nova Scotia	31.47	51.85	—	15.29
New Brunswick	40.13	51.19	—	12.94
Quebec	27.24	29.25	77.37	11.52
Ontario	61.62	71.53	72.72	28.46
Manitoba	41.44	48.81	100.00	24.12
Saskatchewan	31.00	31.48	—	.00
Alberta	46.28	50.24	—	31.13
British Columbia	32.86	24.66	.00	47.07
Yukon	.00	—	—	.00
North West Territories	.00	—	—	.00

¹Includes both general and allied special hospitals.

SOURCE: Unpublished data from the Dominion Bureau of Statistics made available to the Research Unit, Canadian Nurses' Association, 1967.

1965 from the Dominion Bureau of Statistics. This study is a country-wide survey of turnover rates (method of calculation not known) for *full-time* general duty graduate nurses, qualified nursing assistants, and orderlies in public, private and federal hospitals. The results are given in Tables 21, 22 and 23. They show Ontario with the fourth lowest turnover rate for graduate nurses (57.3 per cent) in the ten provinces and two territories; the fifth lowest turnover rate for R.N.A.'s (39.19 per cent); and the highest turnover rate of all for orderlies (61.62 per cent). The tables reveal also that turnover rates in Ontario are highest for graduate nurses in private hospitals and lowest in federal hospitals. This is very much the case, too, for orderlies; nursing assistants leave the federal hospitals most often and public hospitals least often.

To supplement the Canada-wide study of turnover, we did a small study ourselves using only the information submitted for 1966 to the OHSC on their HS-1 form by all Ontario public hospitals. We were interested not only in which class of nurses had the highest turnover, but also in whether the rates differed substantially from one region of the province to another and between small and large urban centres. Tables 24 and 25 summarize the results.¹⁰

First of all the range of turnover rates is great: from 20 per cent to 111 per cent. Furthermore, there are no neat, obvious patterns to it. For example, part-time employees are no more or no less stable than full-time employees on the average. Part-timers are almost 10 per cent more stable (in the sense that 10 per cent fewer quit) than full-time general duty graduate nurses (the largest employee class) but 9 per cent less stable than "all graduate nurses" (a category which includes supervisors of all levels) and about 15 per cent less stable than full-time qualified nursing assistants.

It has been commonly believed that graduate nurses are more mobile and hence more likely to quit than R.N.A.'s, who — because of less education — are more likely to remain in a local labour market and hence not change jobs as much. This is so when comparing full-time graduates to full-time R.N.A.'s. About 18 per cent more graduates quit than R.N.A.'s. On the other hand, 59 per cent of part-time R.N.A.'s leave as opposed to 43 per cent of part-time graduates and 52.5 per cent of full-time graduates. When one adds supervisors, and so on to the general duty graduates, thus creating the "all graduate nurses" category, the turnover rate for full-time graduates approaches that for the most stable full-time R.N.A.'s; although curiously, part-time supervisors are next in instability to the highly mobile part-time R.N.A.'s.

When we look at turnover in different regions of the province, there is

¹⁰There are several ways of calculating turnover rates. We chose the simplest one: the number of "separations" reported for the year divided by the total number of staff on the payroll as of December 31. Though there are weaknesses in this method, it does yield a rate which is useful for comparative purposes.

a similar lack of a clear overall pattern. One might predict that northern Ontario would have the highest turnover rates because of its isolation and generally more transient population, with Metropolitan Toronto a close second due to its being a convenient and desirable stopping place for young nurses of the world "out to see the country". This appears to be the case for full-time general duty graduates in the north, where 57 per cent leave their jobs. But in Toronto, the proportion of 52 per cent who leave is close to the 51.8 per cent who quit in western Ontario or the 48.5 per cent who leave in eastern Ontario. The north has the second lowest turnover rate for both full-time and especially part-time R.N.A.'s (33 per cent and 10 per cent respectively). Toronto again has a high turnover rate for R.N.A.'s (42 per cent full-time; 39 per cent part-time), but this too is not far away from the eastern Ontario rate, at least for full-time R.N.A.'s (41 per cent). The hypothesis for the north and Toronto is best supported in the "all graduate nurses" category: 42 per cent of full-time nurses leave in Toronto, 41 per cent in the north; 53 per cent part-time nurses leave in Toronto and 64 per cent in the north.

The breakdown of turnover rates by size of urban area where hospitals are located shows some surprising results. Here we see rates ranging from 32 per cent to 111 per cent. The most commonsense hypothesis about this variable might be that the big cities would suffer most from turnover because transient nurses prefer large population centres. Although the big cities hardly rate low, there is as much or more turnover in the small cities (50,000 to 100,000 population) and towns (20,000 to 50,000). Only in the small towns and villages (under 20,000) is there a distinctly lower rate of turnover in all classes of nurse, both part-time and full-time. The part-time graduate nurses are noticeably less stable in the big city, whereas the part-time R.N.A.'s leave with excessive frequency in the middle-sized centres (96 per cent and 111 per cent).

Had we had the time and resources, many other variables affecting nursing turnover could have been tested aside from those of region and population size. Foremost among other general influences is hospital size — the impersonality of the big hospital being less conducive to stability than the more flexible structure of small hospitals. This may be so; but the size and congeniality of the immediate work group in the nursing unit and the style of supervision are probably even more significant, and these do not *necessarily* vary according to hospital size. Other factors which no doubt affect the stability of the nursing force in hospitals would be the cost and availability of living accommodation, ease of access to hospital from residence, and amount and kind of recreational facilities in the area — all of which matter much to young single nurses. Policies on vacations and shift schedules would affect the decision to stay or leave for part-time and married nurses.

It would have to be matters like these, which vary from hospital to hospital, which account for some of the unusual findings not reported in the two tables included here. Just as our field visit observations showed "shortages" of nurses in one hospital but not in another in the same area, so the turnover rates were

TABLE 24
Nursing Department Staff Turnover Rates, 1966¹

DISTRICT	Number of Graduate Nurses		Turnover of all Graduate Nurses %		Number of Graduate Nurses on General Duty		Turnover of Graduate Nurses on General Duty %		Number of Nursing Assistants		Turnover of Nursing Assistants %	
	Full-time	Part-time	Full-time	Part-time	Full-time	Part-time	Full-time	Part-time	Full-time	Part-time	Full-time	Part-time
Western Ontario	5,770	2,029	32.1	43.7	3,103	1,750	51.8	40.9	2,107	305	24.8	64.2
Northern Ontario	1,698	636	40.6	64.3	917	506	57.0	52.0	1,128	176	33.4	10.4
Eastern Ontario	2,624	962	38.8	29.5	1,338	799	48.5	30.5	692	90	40.7	24.4
Central and South Central	2,382	798	34.4	42.2	1,294	551	47.0	58.0	883	191	38.0	27.2
Metropolitan Toronto	5,908	1,205	42.0	53.1	3,140	1,022	52.4	47.7	1,402	259	42.4	37.0
All Ontario	18,382	5,630	36.9	46.0	9,792	4,628	52.5	43.3	6,212	1,021	33.9	58.6

¹Includes public hospitals and sanatoria.

TABLE 25
Nursing Department Staff Turnover Rates, 1966¹

Cities, Towns, Burroughs and Villages with Population of	Number of Graduate Nurses		Turnover of all Graduate Nurses		Number of Graduate Nurses on General Duty		Turnover of Graduate Nurses on General Duty		Number of Nursing Assistants		Turnover of Nursing Assistants	
	Full- time	Part- time	Full- time	Part- time	Full- time	Part- time	Full- time	Part- time	Full- time	Part- time	Full- time	Part- time
			%				%				%	
100,000 - 2,000,000	9,624	2,436	42.7	71.4	5,099	1,995	58.4	65.8	1,559	444	40.3	51.5
50,000 - 100,000	3,052	875	40.7	36.9	1,694	748	60.0	38.1	1,009	114	35.1	96.2
20,000 - 50,000	2,073	878	45.5	51.8	1,142	694	59.5	61.5	764	93	39.4	111.4
0 - 20,000	3,633	1,441	32.4	35.8	1,857	1,191	49.9	38.6	2,880	370	20.4	44.8
All Ontario	18,382	5,630	36.9	46.0	9,792	4,628	52.5	43.3	6,212	1,021	33.9	58.6

¹Includes public hospitals and sanatoria.

found to vary widely from one hospital to another within the same town or city. In one case, for example, of a middle-sized town with two hospitals of similar size and type, the rate in one was 26 per cent and in the other 57 per cent.

One final comment on turnover has to do with the commonly held belief that turnover is "naturally" very high for all female occupations relying heavily on young, single people — and that nurses are no different from female teachers or clerical employees. Unfortunately there are no extensive and systematic studies of this; we did, however, attempt to get in touch with a few other employers of large numbers of female employees. This cursory look reveals that most (though not all) of the turnover may indeed be attributable to being female. For example, the turnover rate for female telephone operators in Toronto working for the Bell Telephone Company was 37 per cent in 1967. If one counts only those who left voluntarily, the rate is 32 per cent. As in nursing, the rates are highest during the first six months of employment and decline drastically the longer a woman remains with the company. A large publicly owned service company in Ontario reports a female turnover rate of 20 per cent in the same year. Contrast these figures to the 52 per cent turnover of full-time general duty staff nurses in all Ontario hospitals in 1966. A study of turnover rates for all female employees of one large Canadian bank in 1966 shows an overall rate of 38 per cent as contrasted with 60 per cent for all graduate general duty nurses in Canada in 1965.¹¹

In conclusion, it seems clear that nursing turnover is not all a case of being "pulled" away from a job; that at least some of it may be due to being "pushed" as a result of dissatisfaction with a particular situation. There is little doubt that some of this dissatisfaction, and hence some of the turnover, might be reduced by means of increased attention to employee morale in the hospitals.

Conclusions

Is there a nursing shortage or not? If one's dream is to have a nursing staff of relatively low turnover, full-time, Ontario-trained women, then the answer is "yes", simply because there is at least a 50 per cent turnover rate, about 30 per cent of the graduate nurses work part-time only, and anywhere between 10 and 20 per cent of them may have been trained outside the province (no one really knows this latter figure). If, on the other hand, the problems of constantly recruiting and trying to accommodate and train part-time and newly arrived staff are not considered more than a nuisance, and if, instead, one merely asks if there are enough nurses to meet minimum acceptable standards of care and show statistical improvement beyond these minima every year, then the answer is "no" — there is no shortage.

There is one important factor which none of the existing studies discusses in any detail, yet which is quite significant in deciding how much of a shortage there

¹¹The specific sources of all the above turnover figures for non-hospital employers cannot be revealed, as anonymity was requested by those supplying the information.

is in nursing (if any). This is the amount of nursing which is carried out by student nurses in the latter months or year of their training. In the 1965 OHSC study projecting nursing needs to 1970, student service is included in assessing the manpower supply and is assumed to be constant in amount between 1965 and 1970. In the OHSC studies of 1966 and 1967 (see Appendices) based on nurse:bed ratios for the years 1964, 1965 and 1966, the service contributions of nursing students are not included. Neither of these studies clearly shows the equivalent in full-time employees of the amount of student nursing service given in Ontario. Presumably if the service were totally eliminated today, however, there might well be something of a staffing problem created, given no increase in the number of graduates, no increase in net immigration, and no increase in returns to the labour market of "retired" nurses. Other facets of the student service problem will be discussed in the chapter on nursing education.

The most obvious and definite conclusion to be drawn from this review of data on nursing supply and demand is that more and better studies of this problem need to be made. There is simply no overall study of both supply *and* demand for all categories of nursing personnel in all types of employing agencies. Consequently generalizing is very hazardous. Not only are the amount and classification of data in need of improvement, but, most significantly, there must be more study and discussion of the standards to be used as criteria for determining the adequacy of supply. Standards such as 3.5 hours of nursing care per patient per day; 60:40 professional:non-professional ratio; and the .43 nurse:bed ratio have been used in the past. They make numerous assumptions about the amount and type of nursing care needed, and they are neither universally accepted nor fully understood by the people who must make province-wide policy decisions. It is all very well to say, as nursing officials are wont to do, that the standards of care needed vary from unit to unit, depending on circumstances, but since we have a centrally financed hospital system and various policy decisions must be made on a province-wide basis, *some* standards must be agreed upon. As every hospital must establish, in conjunction with OHSC consultants, an approved staff budget indicating the number and kinds of staff needed, it seems not impossible to us that some change in the OHSC reporting systems could be made to permit a listing of the number of budgeted positions which remain unfilled for a specified period of time — say two months or more in a given year. This might help overcome the confusion between positions which are temporarily vacant due to turnover and positions which are genuinely difficult to fill due to unavailability of qualified people.

Once basic data on shortages are gathered, then it becomes most important to break them down according to such significant variables as nursing class and rank, nursing unit where shortage occurs, the size and type of hospital, location of hospital in terms of region, and size of city or town. Even assuming that there is or will be an overall shortage of nurses, it is crucial to know for certain, for example, whether it is greatest in chronic care hospitals and in hospitals in remote

regions and middle-sized towns, as our own field visit results lead us to suspect. If it is, this suggests something about how to relieve the shortage. Will more young graduates alleviate a shortage in chronic care hospitals, or is this type of nursing so unattractive to them that they will do almost anything to avoid it, including emigration from the province? Will increased numbers of graduates from regional schools and enlarged hospital schools of nursing go to work in short-staffed hospitals in small, remotely located towns which offer little in the way of "husband material" and the type of recreational facilities which appeal to young single women today? We do not know the answers to these questions, but knowing the nature of "shortages" in more detail than is presently available will at least ensure that such questions are asked.

Incidentally, it may seem that such fine breakdowns of supply and demand data as are suggested above would be very time-consuming and costly to carry out, especially on an annual basis. They are not, however, if one makes use of modern high speed digital computers. Neither the OHSC nor the Department of Health has seen fit to put its demand and supply records on such computers as yet. It would help policy-makers immensely if they or some other body charged with responsibility for manpower studies did so as quickly as possible.

Opinion on Nursing Supply and Demand

Opinion on Whether There Is a Shortage

It seems to be a foible of human nature that the fewer facts that are known about a particular issue, the more emotional is reaction to it. This is certainly the case in nursing supply and demand. On the one hand, we have spokesmen for the Ontario Hospital Association asserting frequently and with great fervour that there is a calamitous shortage of nurses.¹² On the other hand, we see representatives of the nursing profession vacillating between claiming there *is* a genuine shortage when they want to justify reducing the training period for registered nurses from three years to two (you can train more nurses faster this way); and claiming that there is not a shortage of nurses but that existing nurses are so inefficiently utilized that there *appears* to be a shortage.

Both groups give the impression of having some pre-existing opinions and preferred states of affairs which come somewhat ahead of any desire to coolly, rationally, and in detail study the facts on supply and demand. In the case of hospitals, it is a simple desire not to have to worry about finding staff or having to give them much in-hospital training; they would prefer also not to have to face the chronic summer shortage problem and would like to be able to open the 100 or 200 new beds in a hospital extension all at once by being able to staff them

¹²For example: "The greatest single problem facing our hospitals today is an acute and increasing shortage of nurses. Statistics indicate beyond any contradiction the critical nature of the present shortage." (Charles Black, Chairman of the OHA Committee on Hospital Schools of Nursing, in *Hospital Administration*, December 1967.)

within a few weeks. In effect, they would like something of a surplus of nurses. For their part, nurses' associations are continuously torn between the service, educational and economic goals they seek. The service goals present a conflict between an emphasis on quantity as opposed to improved quality. The current interest seems to be mainly quality and, concomitantly, increased status. This leads to de-emphasis of sheer numbers of nurses. Educational goals and means to achieve them are in considerable confusion as we shall see; but again, there is somewhat greater interest in improving the quality of education than the quantity.¹³ Finally, the goal of improving the economic well-being of nurses is probably enhanced by a slight shortage, since high demand in the occupation places the nurses in a better bargaining position. In any case, neither of the two most interested parties does much in the way of regular or detailed studies on the issue, nor do they make any effort either separately or together to resolve the problem of acceptable and useful standards for assessing shortage.

The picture then is one of complex, ambiguous and scanty facts permitting very little in the way of well-supported conclusions; and it is confounded by various interest groups with firmly held but basically conflicting beliefs on the issue. In the background, ignored by almost everyone, are the R.N.A.'s, orderlies, aides and clerks who work in nursing departments. They have no organized voice; the OHSC has neither the time nor the staff to devote to studying their supply-demand problems; and both hospital officials and nursing profession spokesmen pay them little heed.

Opinion on What to do About Shortage

If one does happen to believe there is a shortage of some or all types of nursing personnel, the question then is what to do about it. As indicated before, most people assume that the greatest shortage is in the area of nursing done by graduate nurses. This being the case, we see the Ontario Hospital Association advancing the belief that the solution to the nursing shortage lies almost entirely in increasing the number of graduates from Ontario diploma nursing schools; while the officials of the national and provincial nursing associations feel the answer lies basically in the more effective utilization of nursing personnel.

Many individuals and informal groups of nurses and administrators take a much more sophisticated, less doctrinaire approach. In Toronto in 1967, for example, hospital administrators met with representatives of the OHSC and RNAO to organize a major program for attracting back and retraining, if necessary, graduate nurses who had retired from practice.

¹³It would appear, however, that quantity is also a *prime* consideration in asking for reduction of nurse training time from three years to two; and one would wonder then why hospital association spokesmen are generally against this objective. The situation becomes clearer, however, when one recognizes that loss of the third year would represent a decrease in nursing manpower on the wards, because of the elimination of nursing care given by students.

Others express the belief that the shortage is in certain types of hospitals and certain locations, and that an increase in graduates will not necessarily solve it. Such people see the need for intensive local recruitment programs; greater flexibility in the use of part-time staff; and perhaps specially designed and situated training programs specifically set up to prepare people willing to work in remote areas or difficult-to-staff types of hospitals.

While they vacillate somewhat on how much of an overall shortage there is, nurses' groups are fully agreed that there are real shortages in certain subclassifications within the graduate nurse labour force — namely, public health nurses, diploma and university nursing school instructors, and nursing administrators at all levels. Since they do not believe in sacrificing quality for quantity, their preferred solution to these problems is to increase greatly the number of graduates from university degree programs. They feel a degree should be a minimum qualification for admission to all these positions, with the possible exception of some lower level public health positions.

Most hospital administrators agree that there are indeed shortages in these special areas but disagree on the *necessity* of a university degree for admission. They prefer the "temporary" expedient of preparing people for these jobs by means of short courses, year-long certificate programs and the like, while agreeing it might be desirable to get university-trained people in the future.

Decision-Making Structure and Process

The key questions to ask in this section are

- 1) What considerations affect the decision of the individuals to enter, re-enter or leave nursing?
- 2) What are the main controllable policy questions which, in turn, affect the state of the conditions influencing the enter-or-leave decisions?
- 3) Who decides these policy questions?
- 4) What affects the decisions reached?
- 5) What factors govern *demand* for the various nursing classifications?

Regarding demand, the obvious considerations are the rate of expansion of the various health services using nurses and the efficiency of the utilization of nursing resources. The rate of expansion of hospitals is determined largely by the OHSC, and the factors entering into these decisions will not be discussed here. The rate of growth in the public health area is determined primarily by the individual employing agencies, although the provincial government has some financial control. We have already discussed, in Chapter 2, the complex problems involved in better utilization of nursing resources within hospitals in particular.

Table 26 attempts to summarize the key factors in the decision-making structure and process on the supply side of the issue. What matters most to a person who is

contemplating entering or leaving the nursing labour force is not known with any degree of certainty. Therefore, the factors listed in columns 2 and 3 of Table 26 are best thought of as hypothesized determinants of the decision. They are based on our conversations with various people well acquainted with the work patterns of the various supply source groups and on opinions voiced in various newspaper and journal articles and letters.

Given that there is some validity to the conditions listed in columns 2 and 3 of Table 26, the question then becomes: Who has the greatest influence on those conditions (see column 4 of Table 26) and what shapes the kind of influence exerted?

Whether or not the people who form the locus of supply-influencing decisions actually do make conscious attempts to use that influence is determined mainly by how great a shortage they feel there is. The greater the perceived shortage, the greater the pressure to take action. The kind of action taken is determined primarily by what is felt to be the major cause of the shortage. The rest of this section will be devoted to examining how the key decision-makers on nursing resources in recent years arrived at their conclusions on 1) the severity of shortage, and 2) what was causing it.

Decisions on the Severity of Shortage

The OHSC and, less directly, the provincial Department of Health probably have the greatest amount of controllable influence on the supply of and demand for nursing. They control the financing of hospitals and nursing schools, and have considerable power in determining how money may be spent within hospitals; and, by means of pressure exerted through their consultants, they have some influence on how the hospitals will actually be run. More specifically, it is within their power to raise and lower wages; to develop massive programs for the creation and expansion of nursing schools; and to support financially large-scale refresher training, recruitment and publicity programs for various types of nursing personnel. All this is illustrated in the story of the nursing shortage since 1962.¹⁴

It was in 1962 that the Minister of Health first came under pressure on the floor of the Legislature to "do something" about the "growing nursing shortage in Ontario". He then set up a special committee to investigate the situation; the committee was made up of representatives of the RNAO, the OHA, the newly formed (at that time) College of Nurses, the Ontario Medical Association, and

¹⁴The following details were obtained from interviews with a majority of the officials actually involved in the development of policy on the nursing shortage during the period in question. Most of them asked that their identity not be revealed. Suffice it to say that the main elements of the decision process as described by one informant were carefully checked against the descriptions presented by others. Very high agreement among the various informants was found.

TABLE 26
Summary of the Decision Structure Affecting the Supply of Nursing Resources

SOURCES OF SUPPLY	Some of the more important general factors affecting decision to enter, re-enter or leave nursing employment	Some typical policy issues affecting the factors which determine supply	Locus of supply-influencing decisions
A. UNTRAINED			
1. Young women to enter basic nursing training programs.	(a) How favourably the life of a nurse or nursing stu- dent is perceived relative to other available occupa- tional alternatives.	(a) Amount and quality of efforts at "image building" and recruiting.	(a) Employing agencies and their pro- vincial associations. (Provincial government exerts influence through decision on amounts of money to be approved for spending on recruit- ment by employers.)
	(b) Standards of admission.	(b) How "high" or "low" they should be.	(b) College of Nurses sets lower limits for R.N.'s, R.N.A.'s. Each educa- tional program sets own limits within limits set by College if applicable.
	(c) Availability of places in programs.	(c) Number and size of schools; cost of attendance.	(c) Provincial government and top offi- cials of each school or program.
	(d) Wages, hours and work- ing conditions.	(d) Amount of wage relative to alterna- tive occupations; predictability and "fairness" of hour allocation system; policies to improve morale.	(d) Provincial government has major say on those policies involving money expenditure; employing agency decides non-money matters.
2. Men to enter training.	Same as (a) to (d) above.	(a) Special recruiting campaigns directed at men.	See (a) above.
		(b) Special programs for males only or containing high percentage of males.	(b) Provincial government and any authorized persons willing to organize such a school or program.
		(c) Higher wages; clarification of work roles of male nurses of all types	See (d) above.

3. "Older or married women to enter training."	Same as (a) to (d) above plus (e).	(a) Special recruiting campaigns. See (a) above. (b) Possibility of "maturity clause" waiver of usual admission standards. See (b) above. (c) Special schools or programs for older women (e.g., Quo Vadis School, Toronto). See (c) above. (d) Flexibility in systems for assigning shifts, holidays, vacations and part-time work. See (d) above. (e) Tax relief for costs of housekeepers. Day care nurseries for preschool children. (e) Federal government, employing agency plus financial approval from provincial government.
4. "Retired" trained nurses.	(a) Wages, hours and working conditions. (b) Availability of housekeeper or sitter if necessary and at reasonable net cost. (c) Refresher training.	(a) "Attractive" pay rates plus flexibility re shifts and part-time work. See (d) above. (b) See (e) above. See (e) above. (c) Employing agencies alone or in co-operating groups with financial support from provincial government as needed.
5. Trained immigrants.	(a) Eligibility for qualification to practise (if necessary) for R.N.'s and R.N.A.'s. (b) Availability of positions. (c) Similarity of duties and responsibilities to what one was used to prior to arrival in Ontario.	(a) What out-of-province training will be accepted? (a) College of Nurses. (b) What specific positions may be filled by employees with out-of-province training? (b) Employing agency. (c) No specific policy decisions possible for immigrants in this area.

the OHSC. The Administrator of the Hamilton Health Association hospital, who was also a representative on the committee from the OHA, was appointed as chairman.

The committee met three times. At first, the RNAO proposed that a major statistical study be done; but this was voted down, and the subsequent report was based mainly on the experience and judgement of the committee members, plus some data on supply gathered in a survey of member hospitals which had been carried out by the OHA a short time before. This study was primarily an attempt to assess the nature of the R.N. nursing supply. It suffered from the absence of standardized, uniformly interpreted definitions of terms, but nevertheless showed that a fair proportion of nursing service was being provided by graduate but non-registered nurses, married nurses, non-Canadian nurses and part-time nurses. It was agreed by the committee that it was "unhealthy" to be so dependent on these sources of supply; in particular, the finding that about 719 or 5 per cent of the total number of the "professional" nurses reported working in the hospitals surveyed were graduates but not registered was thought to be highly indicative of "a definite shortage of nurses".

The report then went on to make a number of recommendations to alleviate the situation. It was at this time, for example, that the recommendation was first put forward to double the number of nursing school graduates from 2,500 to 5,000 per year within five years. This particular goal figure was "just picked out of the air", according to an informant, although of course it was felt that it would adequately solve the shortage problem. Other recommendations in the report included the creation of regional schools, increase of the number of teachers, greater government financial support of new school building costs, increases in nursing salaries, and major recruiting programs to attract students.

The Ewart Committee Report, as it came to be known, languished between July 1963, when it was first presented, and 1964, when public furor over "the nursing shortage" arose again. The outcry this time was stimulated largely by the publicity given to Riverdale Convalescent Hospital in Toronto opening 600 new beds all at once and having a difficult time trying to staff them. The publicity induced the Minister to create an Ad Hoc Committee on Nursing Education made up of representatives from the OHSC, OHA, College of Nurses, and RNAO.

According to our informants, the Ad Hoc Committee was already "committed" to an "educational" solution to the "shortage", but it nevertheless began by having Miss Grigg do her study of supply and demand (see Appendix III). Interestingly, they apparently instructed her to take *as given* the assumption that there would be 5,000 nursing school graduates per year by 1970. Ambiguous though the results of Miss Grigg's study were, due to some of the assumptions which had to be made about the nature of supply and demand, it was apparently sufficiently convincing to the members of the committee that they could conclude there was and would

be a shortage of registered nurses. Only the nurse members of the committee demurred to the extent that they felt it might not be as severe a shortage as the others seemed to think it was. From what we could discover, other categories of nursing were simply not considered by the committee, or by anyone else for that matter.

Thus by 1965, when the Ad Hoc Committee's report was made and accepted, the provincial government at all levels was fully committed to the belief that there was and would be a general and severe shortage of registered nurses.

Decisions on the Causes of and Remedies for the Shortage

Since the limited statistical studies which were examined by the various government-sponsored committees on nursing supply were not able to pinpoint with any accuracy *where* the shortage of nurses was greatest (in either functional or geographic terms), there were no guidelines as to why the shortage existed or what to do about it. The Ewart Committee, as noted, recognized a number of approaches but emphasized that the main one should be through education of more nurses.

The educational solution was quickly adopted by government policy-makers; and while the need for additional approaches was usually mentioned in official reports on the situation, no specific programs involving these approaches were actually drawn up and implemented.

Why has the educational solution been emphasized to the exclusion of others? Although these reasons are not consciously realized or accepted by the officials involved, our analysis of the situation leads us to suggest the following:

- 1) Although everyone connected with nursing admits that some better utilization of nursing personnel might result in *some* reduction of the number of registered nurses required, only nursing association spokesmen feel this could make a *significant* contribution to reducing the shortage.
- 2) Furthermore, in the eyes of provincial policy-makers, the complexity of devising plans for improved nurse resource efficiency is great and, worst of all, almost impossible to control effectively. Money could be made available to the 250 hospitals in Ontario, but it would be exceedingly difficult for the OHSC to supervise and guide each hospital in using it to improve logistic and communication systems, to develop and fill new nursing support positions, to provide retraining, and so on.
- 3) Hospital administrators, themselves, are not keen to embark on such difficult programs of change in their hospitals; consequently, the Hospital Association is understandably unwilling to strongly advance "better utilization" as a viable solution to shortage and is more than willing to disparage the nurses' associations' advancement of this approach.

- 4) Major expenditures of government-sponsored efforts and money to attract more immigrant nurses and lure back some of the 13,000 registered but non-practising nurses lacks appeal for two reasons. Probably the main one is the feeling that the risk is too great. No one knows how successful such a massive program of attracting "pretrained" nurses would be, since it has not been done before and since so much would depend on the quality of the program — not just on the amounts spent on it. The second reason is that there may still be a lingering bias against immigrants and married women in the nursing labour force on other than a "temporary expedient" basis. It seems that, implicitly at the time, the preferred nurse definitely was young, single, and if not Ontario-trained, at least Canadian-born.

(It should be pointed out that private efforts to recruit immigrants are common and have been for several years. Also in 1967 one major cooperative — though not province-wide — effort was started to get back the "retired" nurse.)

- 5) When it comes right down to it, it is much easier and politically wise for the government to build new nursing schools and to add to old ones. Such structures are noticed, are well publicized, and provide concrete and immediate evidence that "something is being done about the nursing shortage". In addition, the construction provides an economic shot in the arm for the surrounding locality. Nothing like the same impact on the general population could be achieved by programs of internal hospital reform, significantly higher salaries, or even recruitment; in fact, such programs could quite easily generate political embarrassment rather than plaudits.
- 6) Finally, the educational route was taken because it was never seriously or vigorously opposed by nursing spokesmen. The reason was that they saw the emphasis on educational solutions as a means for at the same time securing some long-sought-after improvements in the *quality* of education, and they were determined to negotiate acceptance of these in return for their support of the goal of doubling the number of graduates.

Having taken the story of the decision process up to the point where education was chosen as the chief means of alleviating the perceived nursing shortage, we shall leave it here and take it up again in the following chapters on nursing education.

Although provincial government officials are potentially able to exert the greatest influence on factors affecting the supply of and demand for nurses, they are not the only decision-makers. Who, then, does what outside the government? The roles of the RNAO and the OHA have already been described. The position

and activities of schools of nursing and the College of Nurses will be discussed in subsequent chapters. The remaining major influence is the specific employing agencies themselves.

The activities most open to individual agencies are staff recruiting programs, programs for improving efficiency of staff utilization, and a variety of procedures for enhancing the morale and hence insuring the retention of existing staff. The most astutely and imaginatively run hospitals (and they are to be found in all categories of size, type and location in the province) excel in their ability to attract and retain staff. Having studied turnover in their own organization, they have learned which types of staff will stay longest and which types leave soonest. While they cannot entirely avoid hiring the extreme transients, they learn where to look and how to appeal to the types who are most likely to be satisfied with, and stay in, that organization.

They concentrate on things they know that nursing staff find important and do what they can to alleviate potential dissatisfaction. If they can afford it, they provide cheap but attractive staff accommodation and do not run it like a students' residence. If they cannot afford such luxury, they do what they can to gather and disseminate information on private accommodation.

For nurses with preschool children, one hospital manages to operate a day-care centre. Every effort is made to be as accommodating as possible in terms of assigning shifts, holidays and vacations. This is done within the constraints of the maintenance of standards and the consensus of the staff regarding what is a "fair" system of work time allocation. There is a well-planned and professionally presented program of in-service education with orientation for new staff (all levels) and with continuing training in special procedures and knowledge for special units. The same in-service education system attempts to train head nurses and supervisors in leadership. Surrounding all of these programs is a conscientious effort to maintain genuine two-way communication. Any major change in policy which could have an impact on employee satisfaction is discussed with some or all of the staff before it is decided on, and suggestions and problems from the rank-and-file level are encouraged and acted upon wherever possible. Of course, no single hospital or other employing agency manages to incorporate *all* the above approaches to improved human resource utilization, but some come close and are always trying. Others, it is clear, assume that nursing is still an occupation in which the simple motivation to give service willingly and obediently is paramount; hence nursing personnel should put up with anything in the way of frustrating or substandard conditions of work. In fact, of course, the opposite is true: the more the nurse is taught to think and apply principles rather than to memorize both these

principles and the techniques of practice, and the more she is encouraged to think of herself as an indispensable partner in the health service team (and she has been so taught and encouraged over the past ten years at least), the more she will expect in the way of a professional authority system and exceptional working conditions. Add to this what appears to be a distinct change in the role of women in our society involving greater autonomy, greater desire for meaningful employment beyond the pre-marriage years, and a greater willingness to assume responsibility and authority in employment, and we can see that unless many hospitals radically change their personnel policies, the problems of turnover and "shortage" can only increase.

Chapter 5 Qualifications for Nursing Practice

Introduction

The matter of what qualifications a person must have to carry out the various activities of nursing today is of considerable importance in determining both the supply of nurses and the quality of nursing care. For this reason, a special chapter is devoted to describing what these qualifications are, various opinions on what they should be, and how they are decided. One of the most controversial qualifications, the standards for admission to training programs, will be discussed in the chapters on education.

Current Conditions

Qualifications for Admission to Basic Nursing Practice

As pointed out earlier in the report, anyone may legally carry out the functions of a nurse without any formal qualifications at all. Obviously, such a situation is dangerous insofar as an employer may hire someone to do a registered nurse's or R.N.A.'s job without making sure she is registered, and then allow her to practise without adequate supervision and control. This occasionally happens in nursing homes and in private duty practice. In hospitals, it is common to hire *graduates* of R.N. training programs who have not yet actually obtained their registration. Such people are kept in the minority, more closely supervised, prohibited from performing certain procedures, and paid about 10 per cent less than R.N.'s. Hospitals also hire numerous nurse's aides and orderlies who do not possess registered nursing assistant's standing, yet who may perform some functions done by R.N.A.'s or even by R.N.'s. Such people give most of the actual nursing care provided in nursing homes.

R.N. Qualifications

The qualifications necessary to become a registered nurse in Ontario are laid down in the Nurses' Act and its Amendments and Regulations as administered and interpreted by the College of Nurses of Ontario. The applicant for registration must meet the following requirements:

- 1) She must be a graduate of a school of nursing within Ontario which has been approved by the College.
- 2) She must pass the registered nurse examinations designated by the College.
- 3) She must pay the annual registration fee.

- or: 4) She may be already registered or entitled to renew registration outside Ontario under regulations similar to those of Ontario.
- or: 5) She may be qualified by training for registration outside Canada under regulations similar to Ontario's but prohibited from registration in the foreign jurisdiction by virtue of being a Canadian citizen.
- and: 6) Persons in categories 4) and 5) must pay the same annual registration fee as Ontario-trained applicants.
- and: 7) She must pass R.N. examinations if the Council of the College so requires.

If the annual registration fee is not paid in time, registration is cancelled. It can be renewed simply by paying a reinstatement fee.

In practice these regulations operate as follows. The Ontario-trained nurse need only have graduated from an approved school at any time, have passed her R.N. examination once, and paid the necessary registration or reinstatement fees. In the case of nurses trained in Canada but outside Ontario, each candidate is required to make an application and submit a transcript of her training program. These are reviewed by the Credentials Evaluation Department of the College of Nurses on an individual basis to ascertain that the training program was comparable to that obtainable in Ontario at the time it was taken. In the vast majority of cases, it is so judged and the applicant is registered on payment of the fee. In a few cases, however, the program is deemed deficient in some respects, and the nurse may be required to write an examination in that part or to take a special course in that subject before she is registered.

This procedure differs more or less from that of other provinces in the country. In some, the out-of-province trained nurse can obtain registration simply by obtaining an "endorsement" from her home province stating that she is eligible for registration or is registered in that province. Other provinces have a "case-by-case" procedure for registration of out-of-province graduates similar in general form to Ontario's, but they may apply different criteria for evaluation to the nurse's training program. In Ontario, for example, the applicant must show she has had a minimum amount and type of educational experience in medical, surgical, obstetrical and paediatric nursing as part of her training. In British Columbia, as an additional requirement she must have included four weeks' experience in operating room nursing and dietetics. In other provinces, the registration authorities consider both nursing education and the amount or type of high school education which preceded the nursing program. Such small variations in standards are quite common from province to province.

For nurses trained outside Canada, the conditions are similar to those for out-of-province Canadian-trained nurses. The College of Nurses again attempts

to find out how comparable the training is to Ontario standards. Depending on their judgement, one of four outcomes is possible: 1) If the applicant's training is deemed comparable, she is registered on payment of the fee (the same as "other Canadian-trained"); 2) if the applicant's training is not deemed comparable, she may be required to write some or all of the Ontario R.N. examinations, and if she passes, she is registered; 3) she may be required to take one or more courses in nursing subjects in which she is deemed to be inadequately prepared and then take the examinations; or 4) her training may not be judged adequate in any respect, and she is not permitted to obtain registration without taking the complete R.N. training program in Ontario and passing the examinations.

It is important to note that once a person has been registered in Ontario, it is virtually impossible to keep her off the register except for proven malpractice. No matter how long she has been out of practice or how long she has allowed her registration to lapse, she may practise as an R.N., provided she pays her annual registration fee or the reinstatement fee and subsequent annual fees. In addition, the basic R.N. qualifications are deemed sufficient to permit a nurse to attempt to carry out *any* procedure which has been approved (by physicians or employing agencies) as one which may be done by registered nurses. That is, there are no province-wide legal qualifications for nursing specialists.

Having stated the legal qualifications for R.N.'s, we must note that individual employing agencies can and occasionally do require additional qualifications for their basic nursing positions if they so desire: for example, a university degree, certificate training, or special "in-service" or other courses beyond basic training, single marital status, and so on.

R.N.A. Qualifications

The legal qualifications for R.N.A.'s are somewhat broader than those for R.N.'s. At present, a person can obtain R.N.A. standing by paying the registration and/or reinstatement fee and by 1) taking an approved R.N.A. training program and passing the R.N.A. examinations set by the College of Nurses; 2) having taken now discontinued programs for practical nurses between 1941 and 1944 or a special program set up for practical nurses for members of the military; 3) being a registered nurse outside Ontario but "unable to register in Ontario because of lack of qualification"; 4) having completed nursing assistant training outside Ontario but in a program deemed comparable to Ontario's; and 5) having been registered as a nursing assistant in Ontario "under requirements satisfactory to the Council" (of the College).

In the case of R.N.A.'s trained in Ontario there have been, in the past, waivers for those who have not had approved training programs. The last one was in 1961, when the Department of Health maintained the register for R.N.A.'s. At that time, people who had been employed to perform R.N.A. functions in general hospitals for a certain period of time were granted R.N.A.

standing on the recommendation of their employers, if they applied for it within a designated period of months. It appears also that there will be another waiver of the nursing assistant registration regulations for employees of licensed nursing homes and Ontario (Mental) Hospitals who have been employed five years or longer in an R.N.A. capacity. This waiver, however, will require that the R.N.A. examinations be written and passed before registration is granted.¹

Nursing assistants trained outside Ontario present a more difficult problem to the College of Nurses than do out-of-province R.N.'s, because of the variety of nursing assistant programs in terms of both length and content. In spite of these problems, the College does try to compare each program to the Ontario R.N.A. curriculum, and to decide on that basis.

Other Nursing Classifications

Beyond the "registered" nursing groups, there is a wide assortment of non-registered persons who perform varying amounts and kinds of care and cure activities. The most common of these non-registered groups are orderlies and nurse's aides. For none of these groups is there any form of central control over qualifications. These are established solely by the employing agency. For the most part, the qualifications are quite minimal: perhaps a minimum educational requirement (such as Grade 8 or better), past experience with good references, or successful completion of a training program provided by the employer.

Nurse's aides perform the most routine and unskilled of care duties on hospital wards and in other settings such as nursing homes. It is the hospital orderly group which is the more serious problem. As has already been indicated, a position with this title may involve as little as acting as messenger and male nurse's aide; or, at the other extreme, it may comprise a variety of duties usually performed by R.N.'s and R.N.A.'s. In the best-run hospitals, there is a distinction, therefore, between trained and untrained orderlies, with the former being given a program of in-service training comparable in many cases to that given to R.N.A.'s. These trained orderlies are then paid and worked accordingly. The problem, of course, is that this distinction between trained and untrained orderlies is not always

¹It should be noted, incidentally, that there have been "waivers" for registered nurses. The last one, in 1952, granted automatic registration to graduates trained in Ontario before 1926. Currently, there is pressure on the College to grant another waiver to a handful of graduates from Ontario nursing schools (now closed) which had not received accreditation from the government when these nurses graduated. "Psychiatric" nurses who have received training in special programs in the Prairie Provinces (similar in duration to regular R.N. programs) also feel they should be eligible for R.N. status in Ontario by means of waived or amended regulations. Another source of pressure for waivers comes from those responsible for implementing the new legislation regarding nursing homes which require that both R.N.'s and R.N.A.'s provide certain amounts and conditions of service. The desire is to give automatic registered status to certain staff who have been performing R.N. or R.N.A. duties in nursing homes for a certain number of years.

made by all employers with regard to either training or practice, nor is there any general minimum standard of in-service training. Some programs may be comparable to R.N.A. training, but others fall considerably short of that.

Qualifications for Admission to Specialized Nursing Practice

In terms of actual work performed, it was seen in Chapter 2 that there are a number of positions beyond the level of "general staff nurse" which require skill, knowledge or talents additional to those developed in the course of basic R.N. training; for example, positions in nursing administration, teaching, public health or clinical specialties such as operating room or intensive-care unit nursing, paediatric or psychiatric nursing.

With the exception of teachers in approved nursing schools and public health nurses employed in agencies covered by the Public Health Act, there are no formal qualifications for these specialties which apply on a province-wide basis. To the extent that special knowledge is needed, it may be picked up by experience, in-service training programs, short courses, certificate courses or university training at the undergraduate or graduate level. In the case of teachers in accredited nursing schools, the Nurses' Act Regulations specify that directors be registered nurses with a university degree (of any type), with five years' experience or the "equivalent" of these; and instructors must be registered nurses who have "successfully completed a course in nursing of at least one year at a university acceptable to the Council" (of the College of Nurses), with at least two years of nursing experience (though exceptions to this can be made by the Council). In the case of R.N.A. programs, the only regulation is that the director of a training centre be a registered nurse. Nurses in positions officially designated as "public health nurses" in agencies covered by the Public Health Act must possess at least a one-year university certificate in public health nursing or its equivalent as determined by the Department of Health.

Aside from the legal requirements, each employing institution sets up its own standards of admission to the specialized nursing positions. In most cases these are "preferred" qualifications which can be reduced if no one with the preferred background is available. In a few cases, the qualifications are rigid: for example, nurses may not be permitted to give intravenous injections without having successfully completed a formal in-service training program. For most of the specialized positions, both the minimal and preferred qualifications are highly variable from one employing agency to another.

Opinion on Nursing Qualifications

In general, the spokesman for professional nurses' associations wish to raise, standardize and legalize qualifications. The raising of qualifications is embodied mainly in their views on admission requirements to nursing schools and will be

discussed in later chapters. Regarding standardization, there is a desire to arrive at common criteria for registration across the country. A major program towards this goal is being spearheaded by the Canadian Nurses' Association.

The other area in which the raising and standardizing of qualifications is most desired is in the various specialist positions. Nursing association spokesmen and other leaders in the profession almost unanimously feel that a university degree should be required for all positions in nursing administration, teaching and public health. There is also a growing but very vague sentiment for the creation of some sort of clinical specialist registers and some minimum standard of training for admission to these. These latter aspirations are considerably frustrated, however, by the lack of agreement as to what a clinical specialty is, by the lack of formal programs to provide special training in clinical areas, and by the absence of official positions in hospitals which require formally trained clinical specialists (though there are a number in which the nurse must be a *de facto* specialist of considerable skill to function adequately).

The spokesmen for hospitals are generally opposed to requiring nursing administrators to have university degrees, partly because they do not feel they are needed or useful and partly because nurses with degrees are in extremely short supply. They are basically in favour of university degrees for nursing school teachers, but again do not want to make degrees mandatory until the supply of university-trained is much larger. Regarding clinical specialist training or registers, there is basically indecision mixed with doubt as to how feasible such a system would be. Such indecision will prevail until the profession itself resolves the nature of specialization in nursing.

In all the talk about standards for the nursing profession, strikingly little is said publicly about the current means of registration or the absence of any check on the quality of nursing skill after a period of non-practice. All that is talked about is the system for registering out-of-province applicants, particularly immigrants to Canada. Employers, in general, feel it is too rigid. The most common complaint has been the requirement that state-registered nurses (other than midwives) from the U.K. must take a course in obstetrics and write that part of the R.N. examinations before being allowed to register. At the end of 1967, however, the College of Nurses abolished this course requirement for U.K. nurses, and they may now write the examination directly. Should the experience with this group prove favourable (that is, should there not be many failures), the course requirement for nurses from other countries deemed inadequately prepared in a subject will be similarly removed.

Professional nurses have long wanted not only to raise standards, but ultimately to "legalize" these standards by adopting a system of licensure to replace registration. Such a system would prohibit anyone "nursing for hire"

without a licence and attempt to restrict use of the word "nurse" to only those who possess a licence. The pro's and con's of this argument are discussed at the end of Chapter 2 and will not be repeated here.

With regard to the qualifications of other than registered nurses, publicly expressed opinion is strangely absent. Everyone seems relatively content. Even the small Ontario Association of Registered Nursing Assistants is interested primarily in persuading employers to utilize R.N.A.'s more in accord with their qualifications, rather than upgrading or otherwise changing the qualifications.

Decision-Making Structure and Process

The basic qualifications for R.N.'s are laid down in the Nurses' Act and controlled primarily through the College of Nurses. The College took over the function of nurse registration from the RNAO when it was created in 1963. The decisions about individual applications within the College are made, in effect, by the Credentials Evaluation Committee of the College, acting within the Act and its Regulations as interpreted by the Council of the College. The complex job of trying to assess the comparability of nursing education in jurisdictions outside Ontario falls to a small group of the College's permanent employees who have made a lifetime career of this demanding task.

The examinations for the R.N. are set by the RNAO. The Association does this on a contract basis for the College, primarily because it has experts who are qualified and experienced in devising, administering, and evaluating examinations of this type. In other provinces where there is no college and the provincial registered nurses' association maintains the register, the R.N. tests are modifications of a test designed by the National League of Nurses, a United States professional nurses' organization. New Brunswick is the only other province to use the RNAO test.

At present there is a move afoot to set up a nation-wide testing service so as to standardize the R.N. examination throughout the country. This is another laudable project of the Canadian Nurses' Association which is just getting under way. No one is willing to predict the probability of its success.

The nature of the examination is important in affecting the standards for admission to nursing, and equally so is the system of marking. According to the Executive Director of the College, the procedure is to choose beforehand a "pass mark" which will yield about a 10 per cent failure rate among Ontario graduates writing for the first time. In 1967, for example, the pass rate for new graduates from Ontario was 90.3 per cent. Interestingly, for graduates from outside Ontario the pass rate was 63.2 per cent.

The discrepancy in examination results between Ontario and non-Ontario-trained nurses could be a true reflection of the outsider's inadequate knowledge

of the kind of information deemed important for Ontario nurses to know, but it could reflect also inadequate preparation for the examination rather than ignorance of substantive matters. The new Ontario graduate doubtless is carefully primed in the nature of the examination, the types of questions, and so on (even though the actual questions themselves are changed at intervals). The non-Ontario, and especially non-Canadian, graduate may have been away from formal study for several years and is perhaps unused to the multiple-choice questions which make up the examination. At the very least, it would seem fair that there should be a special booklet prepared to guide the out-of-province graduate in preparing for the examination.

In the case of R.N.A.'s, the decision structure and process for setting the standards for admission are the same as for the R.N.'s. The most noticeable feature of the position of the R.N.A.'s is their inadequate representation in the decision structure. They have but one representative on the Council of the College of Nurses, an appointee of the Ontario Association of Registered Nursing Assistants. Even at that, the acceptance of this R.N.A. position by the College has been a grudging one, as evidenced by the fact that the R.N.A. representative was at first an R.N. chosen to speak for the R.N.A.'s. According to one informant, it apparently took a little government pressure to get a full-fledged R.N.A. seated on the Council.

Although the College legally is autonomous in its responsibility for maintaining standards of admission to nursing practice, it is not fully autonomous in practice. The Minister of Health can bring pressure to bear on the College because of his potential power to propose and obtain amendments to the Nurses' Act, which created the College in the first place. The RNAO clearly has influence for it appoints four members of the College; there are many close ties of friendship between some RNAO officers and Council members; and some Council members have had past experiences in RNAO office-holding. The OHA puts pressure on the Council indirectly through various channels in the OHSC and Department of Health. All these counteracting and largely informal pressures ensure that the College does nothing too radical or innovative to nursing standards which would significantly change the existing quality or quantity of nursing. There has to be considerable demand for the change from more than one of the major interested power blocks or a major groundswell among the rank and file in the profession before an idea has any hope of approval.

Probably the College's greatest weakness regarding standards for practice, as well as its other functions, lies in its lack of financial and personnel resources for doing research which would facilitate its decision-making in areas of concern. Just as the newly formed Council on Health in the Department of Health has been provided with a large and highly competent research and support group in

the Planning and Research Branch, so should the College have a research branch able to conduct studies in some of the major problem areas indicated in this chapter, such as:

The effects of no checks on nursing capability, once registration is granted.

The effects of present procedures for registering out-of-province graduates.

The feasibility of clinical specialties, specialty registers.

The effects of various forms of licensing legislation.

The need for various special waivers and the best procedures for granting them.

Until these kinds of studies can be done and the maximum information gathered on problems such as these, the College will remain largely a political body subject solely to the pressures and counterpressures of the various interest groups in nursing.

Part Two: Nursing Education

Introduction

One of the most important, and least often remembered, facts about nursing education is that it is vocational education. Like training in law, medicine, auto mechanics and plumbing, it is designed primarily to prepare people to perform a fairly specific kind of work which society needs and values. Because its ultimate objective of providing the best possible nursing service to society is qualitatively different from that of general education in science and the humanities, nursing education is, and should be, intricately bound up with the practice of nursing. New developments in the amount and kind of nursing by practitioners should be reflected in the amount and kind of training provided by educators while, conversely, new approaches to practice developed in educational institutions should change the nature of the practitioners' work. Although the mutual interdependence of service and education is obvious to the dispassionate observer, it is often not so obvious to those involved in either activity. Many service-oriented people feel, for example, that education must *only* follow and adapt to the exigencies of service requirements; educators, on the other hand, tend to believe that *they* alone must initiate the innovations to which practitioners must adapt without question. Unfortunately, as we shall see, there has been a growing gap between the educators, and the practitioners and their employers. This dwindling awareness of interdependence represents one of the most serious problems in nursing today.

The following review of the current conditions and problems in nursing education begins with a discussion of education for registered nurses — one part dealing with the quality of this education as shown in problems of curriculum, pedagogy and standards; the other dealing with the quantity of education, and the numbers of students and teachers needed and obtained. Chapter 8 discusses educational problems for non-R.N. nursing staff and Chapter 9, the special area of “in-service” education. A final chapter attempts to integrate the major issues in nursing education through an analysis of the decision-making structure and process.

- c) "Two plus one", regional schools.
 - d) Two years, hospital-based.
 - e) Two years, independent or community college-based.
- 2) B.Sc.N. programs:
- a) Basic: five-year type (diploma course taken in an acceptable nursing school not controlled by the university plus two years university).
Four-year "integrated" type (all training given by the university).
 - b) Post-R.N.: two or three years university after an independently obtained basic diploma training.
- 3) Post-basic programs:
- a) Certificate courses: one year university-based program in public health, administration and teaching.
 - b) Postgraduate: M.Sc.N.

R.N. Diploma Programs

By the end of 1967 there were approximately seventy-two schools of nursing in Ontario which had been approved for training students as R.N.'s. This number is changing almost monthly as new regional schools and university schools are being opened and a very few hospital-based schools close. At the time of writing, there were fifty-two schools based in a single hospital, eight "regional schools", four independent schools offering diploma level education, and eight universities providing training for R.N.'s as part of a baccalaureate degree program in nursing. Of the sixty-four non-university programs, twenty-three offered three-year courses, thirty-five offered "two plus one" courses, and six offered two-year courses.

Indicative of the rapidity of change in the area of R.N. diploma education, in 1965 there were no regional schools; by the end of 1967 there were eight, and ten more are expected within the next five years. In 1965, there were only eight "two plus one" programs; thus, twenty-seven were created in the ensuing two years. There were three two-year programs in 1965 and this number had doubled by the end of 1967, while four more two-year programs have been approved in principle and will probably be under way in another year or two. Put another way, in 1965 over 80 per cent of the existing schools in Ontario offered the traditional three-year program; but by 1968-1969, three years later, less than 20 per cent are likely to be of this type.

As well as changing in structure, schools have been steadily increasing in number. Six new diploma schools opened between 1964 and 1967, and two

universities started new degree programs. Only one school has closed completely, while other new entities have been created as "regional schools" by merging two or more existing schools.

B.Sc.N. Degree Programs

The eight universities which offer B.Sc.N. degrees are Toronto, Western, McMaster, Queen's, Ottawa, Windsor, Laurentian and Lakehead. The latter two are new schools begun in 1967 and 1966 respectively. At the time of writing, Queen's and Windsor still offered the five-year program composed of a first year at university, three years in any one of several established and separate diploma schools, and a final year at university. Both universities have firm plans to change to the "integrated" four year program (university studies plus clinical experience in hospitals and other agencies, with all training under the direction and control of the university). Ottawa began its integrated program in 1965 and Western in 1966.

At five of eight universities in 1967 it was possible for a person who already possessed her R.N. to obtain her B.Sc.N. in specially designed programs of two or three years' length (provided she met university entrance requirements).

Post-Basic Programs

In Canada as a whole, only two universities offer postgraduate education in nursing. McGill and the University of Western Ontario offer an M.Sc.N. There are no programs at the doctoral level in the country. In Ontario, the University of Toronto and the University of Ottawa have indicated their intention of creating Master's programs in the near future. The degree at Western presently is available only in the special fields of administration and teaching.

Until recently, five of the eight universities have been offering one-year certificate programs to R.N.'s in the areas of administration, education and public health. In 1966-1967, Western Ontario dropped its certificate courses in all three areas and Toronto dropped all but its public health certificate. Ottawa is about to discontinue its education certificate while retaining a public health certificate program. Queen's continues to offer public health only. At the time of writing Windsor was the only university offering certificate programs in all three areas, and apparently this university too is currently examining this policy with an eye to revising it. It seems highly likely that, before long, the universities will have ceased to offer all types of one-year certificate programs.

In addition to post-basic training offered in university, there are a number of short courses and correspondence courses for R.N.'s sponsored by the RNAO, the OHA, the CNA, individual universities and individual employing agencies. These programs are available in the subjects of administration, teaching, public health and a few clinical specialties.

Geographic Distribution of Nursing Schools

Three-year and "two plus one" hospital-based programs and regional schools are widely distributed throughout all areas of the province. With the introduction of

the university programs in Sudbury and the Lakehead areas, this form of training has also become thoroughly distributed by region. On the other hand, five of the six two-year programs are in Toronto; and with the advent of the newly approved ones, seven out of nine will be in Toronto, with the other two in Hamilton. Three of the four fully independent schools also are in Toronto, the fourth being in Hamilton. In total, sixteen (21 per cent) of all nursing schools are in the Toronto area, and they enroll almost one-third of the province's nursing students.

Diploma-Level Education

In effect, this chapter is an attempt to deal with the question: which of the various types of educational programs is "best" and should be encouraged, and which is "least good" and should be discouraged?

The first question to raise in approaching this matter is whether the basic division of formal nursing education into three levels — R.N.A., R.N. diploma and R.N. degree — is satisfactory. In making this judgement, we start with the explicit assumption drawn from our analysis of the nature of nursing in Chapter 2 — that there are three distinct levels of nursing activity based on three distinct types of patient need:

- 1) *Simple and standard* physical and psychological care activities. These can be and are provided by registered nursing assistants.
- 2) *Complex, but relatively standard*, physical and psychological care activities, plus simple and standard assistance to the physician in administering the program for "cure".
- 3) *Complex and non-standard* care and cure activities plus the adjunct activities of planning, organizing, coordinating and controlling total nursing service (administration) and preparing nurses to carry out nursing activities (teaching).

If our assumptions are correct concerning the levels of nursing activity and the distinctness of the three classes of nurse needed to carry them out, then it follows that there should be three distinct levels of educational preparation: one for R.N.A.'s; one complex but standard nursing (the general duty R.N.); and one for complex and non-standard nursing, plus administration and teaching (degree R.N.'s). Rightly or wrongly, we accept the basic nature of the present three-level educational system. The rest of this chapter will analyze the varieties of R.N. diploma education and R.N. degree education. Education of R.N.A.'s and others will be examined in Chapter 8.

Curriculum and Pedagogy

The most hotly debated issues on the general question of the quality of R.N. diploma education deal with its overall length, the amount of "practical experience" it should include, and who should control it. In a way, all these are superficial, or at least secondary, issues; for they assume that simple differences in time spent

on a program or time spent in hospital wards, or whether or not a hospital has final say regarding the nursing school budget, will have major and uniformly good (or bad) effects on the quality of the product turned out. Our limited study of this question, by means of reading and visits to nursing schools, indicates that this is not necessarily so.

Let us look at each of the types of diploma training with regard to some of the more fundamental differences in the curriculum and pedagogy.

Curriculum content. Our survey of schools from each of the five types of diploma schools identified on pages 131-132 indicates that, at least on the basis of subjects taught, it is impossible to distinguish consistent patterns between each type. All the schools include some instruction in basic physical sciences, social sciences, the traditional clinical nursing subjects (medicine, surgery, obstetrics, paediatrics and psychiatry), as well as courses relating to nursing history and philosophy, and public health. Most of the schools include also *some* exposure to fundamentals of service leadership, but the *kind* of exposure varies as to whether or not team nursing is taught. Schools vary, but *not* according to basic type, in whether they include special experience in operating room, intensive-care unit and emergency ward nursing: some two-year schools include it, others do not; some "two plus one" schools, both regional and hospital-based, include it, others do not; all the traditional three-year schools we learned about include some O.R. training but vary in the other two areas.

The greatest variation in content is to be found in the amount and depth of material covered in each subject, the sequence of subjects, and how the subject is taught—but, again, the variation is not consistent according to the type of program.

Pedagogy. Leading educators in nursing are fond of contrasting the new developments in the way nursing is taught with the old-fashioned methods. In the old-fashioned programs, students took their classes in blocks of six or eight weeks at a time. Basic science instruction was concentrated in the first months of the program, then nurses were pressed into service on the wards. Clinical nursing subjects made up the bulk of the remaining classroom blocks, but there was frequently little integration between the study of a subject in class and the application of it in the course of work on the wards. Furthermore, the service segment of the program came largely under the direction of service supervisors rather than school staff and was not necessarily planned as a "learning experience". The overall approach in both classroom and service segments of the program emphasized the mastery of procedures by continued practice and repetition, so that one could carry them out perfectly on command upon graduation. Since it was assumed that a physician or experienced supervisor would always be on hand to order the procedures, it was not thought necessary to dwell on the

principles underlying the procedure, to explain why the procedure was necessary, or to go into details about the conditions which give rise to the need for the procedure.

In contrast to this, the modern approach to the teaching of nursing involves the following ideas:

- 1) Expansion of content to include the social sciences and community health.
- 2) Classroom time spread throughout the year rather than concentrated in blocks, and particular attention paid to integrating the theoretical coverage of a subject in class and the practical application of it to patients in hospital or clients in health agencies.
- 3) The broadening of subjects so as to incorporate formerly separate courses under unifying general subject areas. For example, instead of pharmacology and nutrition being treated as separate short subjects, as was commonly done in the past, they now tend to be included in the various nursing subjects where they have relevance. Thus one is not taught "what is a balanced diet" so much as "what are the dietary needs of the maternity patient, the post-operative patient", and so on.
- 4) Emphasis on underlying principles rather than specific techniques and procedures which must be practised for their own sake.
- 5) Planning the sequence of instruction to move from the simple to the complex; from understanding of the healthy, or normal, person to the sick, or non-normal, person.

The important point about all this is that, although there may still be some unknown number of old-fashioned (and thus, in the eyes of nursing education experts, poor quality) programs in the province among the traditional three-year hospital-based schools, the modern approach is to be found in *all* types of schools. It just so happens, however, that the switch from old-fashioned to modern approaches has coincided with the *structural* change from three-year to "two plus one" systems.

One suspects that the reasons for this coincidence are 1) that a radical structural change is a necessary symbolic manoeuvre to bring about important shifts in the attitudes of existing staff and attract up-to-date new staff; and 2) that because the changes in approach were developed and first tried mainly in the United States nursing schools of the two-year variety, the structural features have become implicitly linked with them.

Given that the modern approach to nursing education is to be found in all types of school today, in what consistent and unique ways do the present basic types of diploma schools differ from one another? The only difference of any

significance from a pedagogical point of view is in the amount and distribution of practice required of the students before they graduate. The three-year schools tend to require their students to work regular shifts on wards under the supervision of service personnel in the first two years of the program; whereas the two-year and "two plus one" schools provide only "selected learning experiences" on the wards in the first two years. That is to say, members of the school instructional staff choose areas and limited numbers of certain types of patients for students to nurse as much as possible in accordance with the subjects being taught in laboratories or classrooms at that time. These instructors retain full responsibility for the conduct of the student while she is on the ward. Students are turned over to service personnel for general duty nursing only in their third year, if there is one. It should be added that some schools which are officially "three-year" follow much the same pattern, usually as part of a transition phase prior to becoming officially "two plus one" schools.

The biggest distinction is between the two-year schools and the rest. In these, the amount of on-ward practice is much less. In spite of this, effort is made, as the student progresses through the program, to put her more and more on her own; that is, the amount of guidance and supervision provided by the instructor is reduced, so that typically, by the end of her program, she does about six weeks of regular general duty nursing, supposedly being treated in the same fashion as a graduate R.N.

If the amount of practice is the only *consistent* difference between the various types of schools, what other differences are there between schools?

Use of outside instruction. In the past, nursing instruction was carried out entirely by nurses and selected physicians. In recent years, there has been a trend to have basic sciences and social sciences taught by non-medical specialists from nearby universities. The assumption has been that such people have a better grasp of the basic subject, and that the correct understanding of the subject which is conveyed to the nursing student is a sounder base on which to build nursing applications. Since the advent of Colleges of Applied Arts and Technology on a wide scale throughout the province, regional nursing schools in Hamilton, Windsor and Toronto have made formal agreements with their nearest C.A.A.T. either to allow their students to attend selected regular courses at the college, or to have appropriate college instructors present a separate section of their college course to a class of nursing students.

Though most of the regional and two-year schools lean towards the use of outside instructors, not all do. Nightingale School in Toronto, for example, has adopted the policy of having all subjects taught by its own staff; however, strong effort is made to assign subjects only to staff who have had special training in the basic discipline or disciplines involved.

Amount and type of practice. The College of Nurses, which maintains minimum

standards in nursing education, requires that every school offer at least 750 hours of instruction in theory and 1,500 hours in practice or experience over two years. Within this general guideline, however, variation lies in 1) how one defines practice or experience and 2) how much more than the minimum standard a school wishes to offer in either theory or practice. In the matter of definitions, it is difficult to decide what one should call, for example, practice on fellow students or dummies, or simple observation by students of instructors or others performing nursing procedures on actual patients in wards. Is one practice and the other theory, or vice versa—or can both be considered practice, since neither is based on simple classroom lecture-discussion approaches?

All schools visited during the field study segment of this research appeared to offer more than the minimum of 1,500 hours of practice, if the term is defined broadly as non-classroom, non-laboratory activity; but some schools have a policy of trying to maximize on-ward experience while others have consciously decided that something near the required minimum of on-ward practice is satisfactory, provided the effects of it can be simulated in other ways. These differences in policy are to be found mainly within existing two-year programs, indicating that there is no truth to the charge that all two-year programs de-emphasize practice. "Two plus one" schools also vary somewhat, though there is a slightly greater tendency to favour the maximization of selected and guided on-ward learning experience. Aside from the amount of practice, there is also variation as to how much a student will be allowed to do for patients, how closely she is supervised, and whether or not she is exposed to evening or night shift experience.

Clinical and other educational facilities. Schools differ markedly in the amount and type of facilities they have under their control for enhancing the learning experiences of students. Clinical facilities refer to access to various types of actual patients on whom the student can practise application of her nursing skill and knowledge. Some schools have had difficulty in obtaining access to all types of patient. For example, some cannot provide what they feel is enough experience in maternal and infant care. Others would like to be able to expose their students to more complex cases of surgical nursing; while still others have what they feel to be inadequate exposure to public health nursing, psychiatric nursing or chronic care nursing. This problem of lack of complete clinical facilities has been greatest for schools which are entirely independent of hospitals (such as those at universities, Quo Vadis, Ryerson Polytechnical Institute). It also plagues schools based in hospitals in less central locations where the diversity of illnesses is not so great.

In addition to sheer quantity of exposure to clinical areas, there is the problem of quality. Nursing school directors are quite conscious of the fact that hospitals may vary in the up-to-dateness of the procedures they follow and in their ability to provide the complexity and diversity of cases that is ideally desirable for a student to be exposed to during the limited time she has in any given area.

Schools vary also in their awareness of and ability to afford a growing variety of teaching aids and special facilities which enhance the student's learning experience. These range from audiovisual aids such as films and closed circuit television, to science laboratories and various kinds of dummy patients, to simulated nursing station centres which can approximate the real work situation. Typically, the schools most conscious of these special aids and facilities are those which have the greatest difficulty in obtaining adequate clinical facilities for their students.

Teacher-student relationships. Another area in which schools were found to vary considerably was in the amount and kind of student-teacher interaction encouraged. At one extreme are a few schools who still maintain fairly rigid authority structures in which the students are *told* what to do and how to do it with little opportunity for feedback or individual work. At the other extreme are those who conscientiously encourage student participation in all phases of their learning, who seek out student reaction to their experiences, and who provide the maximum opportunity for students to go beyond the basic curriculum and engage in individual projects and assignments pertinent to nursing. The majority of schools are moving gradually towards this latter end of the continuum as a result of their decision to emphasize "principles" and underlying reasons for nursing activities, rather than activity learning only.

Length of programs. Aside from the broad differences already mentioned regarding program length (two years, two plus one, three years), there are additional differences among schools in time spent in the program. Thus there are some variations among schools in the length of the school day, the number of days in the week that the student attends, the number of weeks in the school year and the length of holiday and vacation periods. Variations in these can have a considerable effect on the total length of time available for instruction above the minimum requirement.

Standards for Students and Teachers

1) Admission Standards for Students

Current admission requirements to R.N. diploma programs vary above a basic minimum laid down by the Nurses' Act. From October 1965 to August 1967, the minimum was that an applicant had to have been enrolled in the university entrance (five-year) program at high school, have completed at least grade 12, and have had grade 11 and 12 chemistry and one of physics, botany or zoology. Prior to that date, graduation from the General Course in high school with the same sciences was deemed satisfactory. Since August 1967, the Act has been amended to again lower the requirements to grade 12 of the four-year, or non-university entrance, program and require grade 10 mathematics (for the first time) plus chemistry and either physics or biology. There is also the addition of a "mature student" clause (to remain in effect until the end of 1975) specifying that people over twenty-five will be eligible for admission without meeting any of

the other requirements, provided they have achieved "successful completion of a four-year course in a secondary school as determined by the Minister of Education". There is also a new provision allowing university degree holders (from universities acceptable to the Council of the College of Nurses) to qualify for admission to diploma schools without having met the high school science requirement. In all cases there is provision for assessing "equivalent" standing by the Minister of Education in cases of application from jurisdictions outside Ontario.

Beyond these minimum requirements in the Nurses' Act, individual schools may impose additional requirements, either academic or non-academic. They may insist on completed grade 13 or grade 12 in the five-year program, and they usually specify a minimum grade average of 60 or 65 per cent while the Act requires only "successful" completion. In still other schools, preference is given to those with progressively higher qualifications. Thus if the schools are *able* to fill all their places with applicants with partial or complete grade 13, the net effect is that the four-year program graduate is excluded in spite of the amended Nurses' Act. Table 27 summarizes the minimum academic entrance requirements for diploma nursing schools as reported by the Ontario Hospital Association. It will be seen that only *one* school accepts the minimum laid down in the Nurses' Act. The majority accept grade 12 but specify a 60 per cent grade average. The vast majority also state a *preference* for students with partial grade 13 standing. *All* two-year schools require at least some grade 13.

Aside from academic qualifications, the Nurses' Act requires a "medical certificate of good health". Most schools set a minimum age requirement of

TABLE 27
Minimum Academic Requirements for Admission to
Diploma Schools of Nursing in Ontario, 1967

Grade 12 (4 or 5 year programs)	— pass (50% overall grade average)	— 1
	— at least 60% " " "	— 29
	— at least 65% " " "	— 6
Some grade 13 credits		— 5
Grade 13 diploma		— 4
Minimum acceptable requirements not stated ¹		— 13

¹The majority of schools in this category state a *preference* for some or all of grade 13 but do not *explicitly* state if students with less will be considered, given that not enough "preferred" applicants are obtained.

SOURCE: *Schools of Nursing in Ontario*, Ontario Hospital Association, 1967.

seventeen and some will not take students over thirty. In the case of Quo Vadis School of Nursing in Toronto, applicants are accepted *only* if they are between the ages of thirty and fifty.

There are still twenty-five diploma schools in the province which refuse to take males. Others will take males only if there are more than one or some other minimum number of male applicants. It is worth noting that, among large urban centres in the province, in Ottawa alone is it impossible for a man to obtain nurse's training. None of the four schools there will consider applications from males.

A few schools make use of letters of reference to assess "moral character" and some require applicants to take aptitude and achievement tests. Almost all require a personal interview with a school official. It is impossible to list any clear criteria of selection applied to the results of these references, tests or interviews, though there is little doubt that some unknown number of girls who otherwise meet the qualifications do get turned down as a result of their performance in these secondary areas.

2) Performance Evaluation of Students

On average, around 14 to 19 per cent of the students starting nursing in Ontario in any given year drop out of the program; and of these, the percentage leaving for academic reasons is between 40 and 50 per cent. This means that there is a "failure rate" in diploma nursing schools of between 6 and 10 per cent.

The bases for evaluating student performance are partly a relatively objective marking of written assignments and examinations, and partly a basically subjective evaluation by teachers of the students' ability in the clinical or practical areas of the curriculum. Nursing instructors are the first to admit the difficulty of accurately assessing the clinical performance of students, and we understand most schools are continuously attempting to improve in this area. The most common technique involves multiple ratings by several teachers and any service supervisors who have had an opportunity to observe the students. In a few of the more "progressive" schools the student herself is involved in the rating procedure by assessing herself, discussing the ratings of others, and setting specific improvement goals for herself.

3) Qualifications for Faculty

The present minimum requirement for a teacher laid down in the Nurses' Act is two years' experience "in nursing" and successful completion of a "course in nursing of at least one year at a university acceptable to the Council", or the equivalent of this as determined by the Council.

In 1966 there were 960 teachers in Ontario nursing schools, of which 904 were employed in diploma schools and 56 (6 per cent) in university schools.

These 960 teachers had the following qualifications:

	Ph.D.	M.A.	Baccalaureate	Certificate	Less
Director	2	18	38	6	
Asst. Directors		6	32	7	
Teachers		40	330	289	192
Totals	2	64	400	302	192

SOURCE: Ontario College of Nurses.

From the above, it can be seen that 49 per cent of the teaching faculty had university degrees of some sort and 51 per cent did not. A full 20 per cent did not even meet the minimum current requirement of the one-year certificate and presumably have been judged as having the equivalent of this by the College of Nurses in order to teach. If one considers only the 904 teachers in diploma schools, in 1966 46 per cent were degree-holders, 54 per cent were not.

For comparison purposes, according to figures from the Canadian Nurses' Association, in 1965 the degree to non-degree ratio in Ontario was 38 per cent:62 per cent — indicating a striking 8 per cent improvement in number of degree-holders in one year.

To place the Ontario situation in perspective with the rest of the country, compare the 1965 38 per cent:62 per cent ratio with the western provinces, 44 per cent:56 per cent (7 per cent better); Quebec, 33 per cent:67 per cent; Atlantic Provinces, 23 per cent:77 per cent.

Distribution. The six university schools of nursing employ no teachers with less than a baccalaureate and almost half of them possess a Master's degree. As of the end of 1967, only six diploma schools employed virtually none but degree-holding teachers — Hamilton Health Association, Ryerson Polytechnical Institute, Nightingale, Quo Vadis, Osler Regional and Pembroke. Significantly, four of the six are relatively new two-year schools. Beyond this, it is impossible to distinguish among types of programs or parts of the province in terms of the proportion of degree to non-degree teaching staff. For example, a three-year program like that at Niagara Falls may employ seven degree to two non-degree teachers, while a two-year program like that newly begun at St. Joseph's, Toronto, may employ nineteen degree nurses to thirteen non-degree. One small, relatively out-of-the-way "two plus one" school, Pembroke, in 1967 employed seven with degrees out of a total of seven, while another "two plus one" school in Toronto had seven teachers with degrees and eight without.

Staff:student ratio. A rough guide to the quality of education often used by educators is the ratio of teachers to students, the assumption being that if there are "too many" students per teacher, she is unable to pay adequate attention to individual student development. On the other hand, educators are quick to point

out that while a high ratio is a danger signal, a low ratio in no way guarantees that high quality education is taking place. At best, it is a necessary but not sufficient condition for quality.

Unfortunately, we were unable to discover precisely how the various schools compare on the teacher:student ratio. We do know that province-wide there were about 900 nursing teachers and 8,500 students giving a ratio of between nine and ten to every teacher. This is in line with our finding that the OHSC and many schools look on a ratio of ten to one as an acceptable standard in a very general way. The "ten to one" standard is useful at only the broadest level and is nowadays rarely applied rigidly to any particular school. Its drawbacks are that it does not in any way reflect the calibre of the staff; nor the amount and kind of assistance provided by service staff; nor the amount of teacher time "wasted" due to performing clerical duties; nor travel to clinical facilities; nor an adequate quality and quantity of both school and hospital facilities.

We could not definitively calculate and compare teacher:student ratios because it is difficult to ascertain the total number of students in a given school in a given year; the only figures available are the numbers *entering* a school each year. Using these entrance figures, multiplying them by the number of years in the program and making allowance for total attrition of 20 per cent, we get the following kinds of teacher:student ratios in a random sample of eight schools in 1966:

2 yr.	program enrolling	61	into 1st year	with 16 teachers	— 1:6
2 yr.	" "	32	" " " "	11 "	— 1:5
3 yr.	" "	66	" " " "	10 "	— 1:16
3 yr.	" "	43	" " " "	8 "	— 1:13
3 yr.	" "	138	" " " "	35 "	— 1:9
3 yr.	" "	123	" " " "	24 "	— 1:12
"2 + 1"	" "	61	" " " "	19 "	— 1:7
"2 + 1"	" "	58	" " " "	14 "	— 1:10

From these figures it would appear that the teacher:student ratio is lowest in the two-year schools and higher but quite variable in the remainder. The problem is, however, that in some three-year and all "two plus one" schools the third year of study usually involves very little teaching or supervision by the teaching staff as the students are largely under the direction and control of service staff. A more accurate measure of the teacher:student ratio, therefore, should take some account of the "teaching" component of service staff. The more important general point to note is the considerable variation in ratios over all schools and even within the same type of school. That such diversity does in fact exist and is not just the result of biased assumptions or a non-representative sample, was generally supported by the comments of nursing school directors and the chief nursing consultant for the OHSC in the course of our field visits.

Summary

It seems that, using the few criteria available to us in a study of this type, the firmest (yet hardly earth-shaking) conclusions we can come to about the quality of diploma nursing education in Ontario is that it is 1) variable and 2) not consistently high or low within any of the types of school operating in the province. Admittedly, some three-year schools have been seemingly loathe to adopt modern approaches to curriculum and pedagogy; but aside from those, to know only the length and structure of the program is simply not enough to predict that it will or will not be a "good" school.

University-Level Education

Nursing education in Ontario universities is offered at three levels: the certificate level, the bachelor's degree level and the postgraduate level.

Bachelor's Degree Programs

Five-year non-integrated programs. Though two of the eight universities were still offering these programs as of the end of 1967, both are committed to discontinuing them as soon as the number of qualified staff and availability of clinical facilities make it feasible to do so. For this reason, we will not describe the nature of these programs in any detail. Essentially they are being collapsed to four years in accordance with the belief that basic nursing education can be given in two years instead of three by reducing the service component in training and by restructuring the curriculum and pedagogy.

Four-year integrated programs. The usual university program for nursing differs from the average modern diploma program in several significant ways. Students take more in the way of the natural and social sciences, usually in the form of regular courses offered by the faculty of the respective departments within the university. They are required also to take elective courses outside the nursing faculty which may be in the humanities or additional subjects in the natural or social sciences. In the course of the four years, students receive considerably more instruction and practice than diploma students in the specialized areas of public health, nursing service, leadership and administration, and nursing education.

Aside from these major differences, there are also a number of similarities between the university programs and the most up-to-date diploma programs. The approach to specifically nursing skills and knowledge is similar in structure and content to that described in the previous section. The total amount of clinical practice falls somewhere between that received in two-year diploma programs and "two plus one" or three-year programs. Just as in diploma training, there has so far been no attempt to make the baccalaureate nurse more proficient in clinical specialties such as surgical, paediatric or psychiatric nursing.

Standards of admission and performance in the university programs are inevitably somewhat higher than in diploma programs, since they are determined

on a university-wide basis. At minimum, applicants must be graduates of the university-entrance stream in high school and must have 60 or 65 per cent grade average. Once in the program, students are graded in those courses taken outside the nursing faculty on the standards used by the other departments. Within the faculty, the standards for passing and failing also must conform to university-wide regulations, although there are the same problems of the subjective assessment of practice that confront the diploma programs.

The drop-out rate in university programs is somewhat higher than in diploma programs. The study on nursing education by the Royal Commission on Health Services indicates an annual attrition rate for 1962 of 32 per cent in all Canadian university nursing schools, as opposed to the 20 per cent for diploma schools, with the greatest proportion of this—about 64 per cent—being due to academic failure. A questionnaire survey of Ontario nursing schools by the Committee on the Healing Arts in December 1966 indicates an attrition rate of approximately 25 per cent in the university schools in the academic year, 1965-1966.

Faculty qualifications in university nursing schools are naturally higher than in diploma schools. All have Bachelor's degrees and thirty-two out of a 1966 total of sixty-six have Master's degrees. In 1967 there were still fewer than five who had managed to complete Ph.D. degrees. A great majority of those without the Master's degree have credits towards it, and a lesser number of Master's holders have some work completed towards the Ph.D.

Post-R.N. Bachelor's programs. Five of the eight universities offer special programs for students who have already obtained their R.N. in diploma programs. Until recently, these were two years in length and consisted primarily of one year of university-level subjects in basic sciences, social sciences and humanities, and one year of relatively specialized training in one of the traditional special fields of public health, administration or teaching. It was thus highly similar to the old five-year non-integrated programs for non-R.N. students. In fact the two groups often took the same courses together.

At present all but one of the two-year post-R.N. degree programs have been changed to three years in length. The exception is the University of Ottawa. During these three years, the post-R.N. student acquires the same amount of exposure to the natural sciences, social sciences and humanities as the "regular" student in an integrated four-year program, plus the same kind of specialized training in public health, teaching and administration. The addition of the university level material, plus the belief that basic nurse training is equivalent to only two rather than three years of study, is the rationale for the one-year increase in the length of the post-R.N. program.

Post-R.N. Certificate Programs

Nowhere is the conflict between quantity and quality in nursing so clearly illustrated as in the treatment of one-year post-R.N. certificate programs in nursing

at universities. On the one hand, there seems to be a crying need for nursing administrators and teachers with at least *some* specialized knowledge of these highly complex specialties beyond that picked up solely through on-the-job experience. On the other is the belief of educators that an even greater need exists for a large body of nurses with full baccalaureate-level training, and that the increase in competence in performance as a teacher or administrator as a result of certificate program training is small relative to the total amount that could be learned. Faced with extremely limited numbers of qualified faculty, the universities have had to choose between certificate and degree training. They have chosen to abandon the certificate training in teaching and administration in order to expand basic degree programs. (The only reason that the certificate program in public health has not been abandoned extensively is apparently that the Public Health Act requires the certificate as a minimum qualification for employment as a public health nurse. Paradoxically, the same requirement for teachers in diploma schools has *not* been a consideration in the decisions to drop the teaching certificate programs.) As of 1967, the University of Ottawa alone continued to offer certificate courses in education. It was alone also in offering the certificate in nursing service administration. Both these certificate courses were to be phased out over 1968-1969. This trend towards the abolition of certificate training will be analyzed in the chapter on decision-making.

Opinions on Nursing Education

Opinions on who should control the quality of R.N. education, how decisions should be reached on this matter, and how decisions actually are reached will not be presented in this chapter. Since they are inextricably bound up with considerations of quantity in the minds of both decision-makers and other concerned groups and individuals, all matters relating to decision-making and control in nursing education will be discussed in a separate chapter. Current conditions in all facets of education and opinions on these are reviewed in the remainder of this and the next two chapters.

Probably no aspect of nursing gives rise to greater controversy *within* the nursing profession than nursing education for the registered nurse. It is a subject on which every nurse seems to have a strong opinion. The most hotly debated issues of primary concern to the *quality* of education alone are how long it should take to obtain a "good" nursing education, and how much practice in actual nursing service in hospitals and related agencies is needed to turn out a "good" diploma graduate. Other issues—such as what subjects should be taught, in what depth and breadth, in what sequence, and by what means—also are subject to continuous debate and discussion, but only among nursing educators. Questions such as "proper" admission and performance standards for students and "acceptable" qualifications for nursing teachers, too, are widely debated both within the profession as a whole and by concerned non-nurse authorities; but these matters, though quite relevant to quality, are inseparable from considerations of the desired quantity of graduates, and will be discussed later.

Program Length and the Practice-Theory Debate

The great majority of currently practising registered nurses seem to harbour considerable doubt about the adequacy of a two-year nursing education, even though they have not actually worked with two-year graduates. Most, when asked about the matter, hark back to their own training days with the long hours of service and the early and continuous requirement that they handle pressure and take full responsibility for nursing care. How, they ask, can a two-year graduate with her limited exposure to practice, most of which has been closely supervised by an instructor and almost none of which has been given under pressure of a full patient load, possibly cope with the real world of nursing — the world of lonely midnight shifts, frequent crises, responsibility for too many unpredictable and demanding patients, paperwork, empty supply cabinets, and impossible doctors and internes?

When one asks present-day head nurses about the two-year programs, the response is predominantly similar to that of staff nurses from three-year programs *unless* they have had actual experience in supervising a two-year graduate. Among this latter group (and it is small because so few two-year graduates have been produced in Ontario as yet), the answers vary from the standard. The most common response is that it took her (the two-year graduate) about six months to “get adjusted”, or “learn the ropes”, or “learn to work at the same pace as the rest of the staff”, after which she was “O.K.” On either side of this are a few who have had a poor experience with a single two-year graduate and a few who said one or two they had supervised were “even better” than the “usual three-year girl”.

Among supervisors, the rank above head nurse, as well as among a few head nurses, the responses are more sophisticated. Some say it depends which two-year school you are talking about, realizing that, among other things, graduates vary as to the amount and kind of clinical experience they get during the two years. However, whether or not they have actually observed two-year graduates working, the majority are, like the head nurses who have worked with them, willing to say they are “good” nurses once they get a little experience under their belts, but that up to that time they tend to need more supervision, instruction and support than the new three-year graduate.

The farther away a nursing official is from the actual bedside, the more unqualifiedly favourable opinions she tends to have about the two-year nursing program. At the director level and certainly among virtually all teachers and school directors, there is strong positive belief that the two-year is preferable to the three-year program for educating the basic nurse. When asked about charges that the two-year graduate is unsure of herself, inept at performing routine nursing procedures, and unable to accept pressure, responsibility and shift work, the

standard response is that "all she needs is a little experience" or that in this respect she is no different from the fledgling teacher, engineer or auto mechanic — and "who expects *them* to be perfect on the first day of work?"

The above-mentioned charges *against* the two-year programs are often most vehemently levelled by representatives of the Ontario Hospital Association, a number of individual hospital administrators and some doctors. (Most doctors, however, are quite silent on the issue. They do not seem to care *what* kind of basic training the nurse gets so long as she is amenable to useful specialized training later.)

So much for the essence of the conflicting opinions. Is there any evidence to support either side? The most carefully and systematically designed studies published have been done on "demonstration programs" — the trial two-year programs first introduced in the United States. In a way, such studies are biased towards showing success, because the "demonstration" goes all out to make things work. The very best teachers are attracted to the new approach; student:teacher ratios tend to be low; budgets are a little more lavish than average; the students are a little more carefully selected and are imbued with the realization that they are "very special" and that they carry the reputations of respected teachers on their shoulders. Given all these tendencies, it is little wonder that the most widely known study of "associate degree" programs for nurses in the United States (that is, two-year programs mainly located in community colleges),² the only published study of a two-year program in Ontario,³ and one study of a two-year program in Saskatchewan⁴ all show that the two-year graduate makes a perfectly acceptable general duty registered nurse.

Less detailed and systematic evidence gathered through a survey of the employers of about fifty graduates from one of the other two-year programs in Ontario similarly shows that they were considered fully satisfactory employees within four to six months of their first full-time employment.

In our search of the literature, we found no detailed, long-term, methodologically sound empirical studies of specific two-year programs which concluded that their graduates were generally inferior to those from more traditional programs. The most we could find on the negative side were a few articles by doctors or administrators describing their impressions of such graduates presumably as a result of personal observation of them. One of these articles, for example, claims that the two-year graduates were insecure, incompetent and unable to take the pressure of hospital nursing, and that being trained in schools not based in hospitals

²Mildred L. Montag, *Community College Education for Nursing*, McGraw-Hill, New York, 1959.

³A. R. Lord, *Report of the Evaluation of the Metropolitan School of Nursing, Windsor, Ontario*, The Canadian Nurses' Association, Ottawa, 1952.

⁴Reported in *Report of the Ad Hoc Committee on Nursing Education*, Province of Saskatchewan, 1966, pp. 92-99.

(that is, in community colleges) leads them to try to avoid hospital jobs on graduation.⁵

As a result of our own examination of programs of all types, we came to the following conclusions, which were hardly startling in themselves but which nevertheless seemed not to occur to many of those engaged in attacking or defending any particular system:

- 1) The quality of education at present varies from school to school almost independent of whether it is a two-year, "two plus one" or three-year program. The calibre of faculty in terms of formal qualifications and teaching ability, the student:teacher ratio, and the *quality* of clinical experience in terms of its variety and complexity are just a few of the variables which rank above simple program length in shaping the adequacy of the training received.
- 2) In the last analysis, the decision as to whether a two-year or three-year education is "best" depends largely on the employer's expectations regarding what the new graduate should be able to do immediately on starting work. It seems generally agreed, for example, that it takes the average new two-year graduate anywhere from four to six months to get enough experience in performing certain routine nursing procedures before she is as proficient at them as a three-year graduate who has spent a considerable proportion of her latter period of training acquiring her proficiency through service. Incidentally, part of this four to six-month "breaking-in" period — perhaps up to six weeks of it — consists of becoming oriented to a *particular* job in a *particular* hospital with its own unique set of rules, procedures, forms and other practices. In this respect, the graduate nurse is in the same position as *any* new employee of having to get used to an unfamiliar job and employer.

At any rate, the point is that *if* the employer is not aware of the two-year graduate's need for a few months of guided practice before she can accept the same amount of autonomy and responsibility as those with more experience, and *if* he or his supervisory staff are not willing or able to provide this period of guided practice, then the two-year graduate might well be viewed as unsatisfactory by some of her supervisors and fellow nurses. If, on the other hand, the two-year graduate is expected to possess simply the basic skill and knowledge for general duty staff nurse work but not necessarily complete proficiency or self-confidence in the performance of all facets of the work, then she will be deemed eminently satisfactory.

The reason, then, for the inability of educators and some nurses and

⁵Thomas Hale, M.D., "Problems of Supply and Demand in the Education of Nurses", *The New England Journal of Medicine*, November 10, 1966, pp. 1044-1048.

administrators concerned with service to reconcile their views on two-year education is primarily that each side has different expectations of the goal of nursing education.

It should be added at this point, however, that if it is in fact true that the average two-year graduate needs four to six months before she is able to perform normal nursing duties satisfactorily with the normal amount of supervision, and if two year programs come to form the most common training for registered nurses, most hospitals and other employing agencies will have to be given money, staff and advice for developing a specific program to provide a special form of in-service training for new nursing graduate employees. This problem will be elaborated in a later chapter.

- 3) The conflict between educationists and service personnel is further exacerbated because of other differences in expectations regarding the end product of the educational system. The ideal of leading educationists is a nurse who is as interested in the socio-emotional side of care as in the physical side, who wants to know the reasons for the procedures she is asked to perform and, when possible, actually to participate in diagnosing the patient's nursing needs; and who prefers to think for herself — allowing the patient's condition and her own knowledge of nursing principles to suggest what should be done for the patient instead of simply following a supervisor's orders.

Many service leaders also subscribe to this ideal in theory. But the most sophisticated of them realize that in certain circumstances it is not feasible to implement it and that certain nurses, no matter how much they wish to behave in accord with the ideal, are incapable of doing so. They wish the educators would build into their programs more of the "realities" of nursing life. Another large proportion of service leaders are not so analytic in their view. While they, too, may publicly agree with the educators' ideal, in their heart of hearts they yearn for the "old-fashioned" graduate who came out letter perfect in procedure and did what she was told quickly, efficiently and without question. Understanding of reasons, participation in decision-making, and independence of action came, if at all, as a result of long years of experience, at which point the graduate could expect to be promoted to a leadership position herself. For service leaders with this implicit model ingrained in them and faced with the complexities of handling a group of girls who bemoan not being able to give socio-emotional care, who want to "waste time" discussing the "nursing diagnosis" and who cannot even be trusted to carry out simple procedures perfectly for several months after graduation — for such leaders the "modern" educational approach seems quite wrong.

General vs. Vocational Education

Aside from the length of diploma nursing courses, there is the matter of what should go into the educational period. Traditionally, the concentration has been on learning matters of greatest relevance to basic bedside nursing. Today, however, some educators urge that at least half the programs comprise "general education" in the natural and social sciences on the assumption that 1) such a base is vital to permit nurses to develop beyond the level of giving routine bedside care; 2) nursing education should have more than narrow vocational goals — it should prepare a generally better educated person for society as a whole. Other nursing educators are not certain whether half of the program in basic disciplines is not more than is necessary for competent nursing beyond the basic level, and they therefore question to what extent an essentially vocational education should be responsible for trying to fulfil broad social objectives. They feel that no more than one-third of a two-year program need be in the basic sciences. At the furthest extreme is a relatively new experiment in two-year education in England (two years and two months to be exact) in which the approach is almost entirely "practical" learning in a clinical setting with a minimum of classroom theory. We are in no position to evaluate the merit of various pedagogical approaches, but we were struck by the relative paucity of empirical or experimental data contrasting the effects of various approaches within two-year programs on ultimate performance in nursing. We obtained the strong impression that the debate among educators more often than not was based on a prior emotional commitment to one approach or another, with little willingness to suspend judgement until such evaluative data could be obtained. It must be added, however, that at present the profession possesses very few individuals qualified to carry out these types of evaluative studies; nor does it presently have sufficient funds or control over educational institutions to set up such experiments. It was only in mid-1967, for example, that arrangements were made to start an evaluation study of the two-year nursing program at the Ryerson Polytechnical Institute in Toronto — a program which emphasizes "general education" and de-emphasizes on-ward learning experiences relative to other two-year programs in the province.

Chapter 7 The Quantity of Education for the Registered Nurse

Current Conditions

This section reviews current and expected enrolment in nursing schools, number of graduates per year, and number of recruits for nurse training at the diploma and degree levels. It also discusses the supply of teachers.

Enrolments and Graduates

Table 28 shows the total enrolments and graduates from Ontario nursing schools from 1965 to 1967.

TABLE 28
Enrolments and Graduations, Nursing Schools Preparing Registered Nurses, Ontario, 1965-1967

	Diploma School Enrolments	Degree School Enrolments	Total Enrolments	Total Graduates
1965	3,474	121	3,595	2,592
1966	3,472	160	3,632	2,538
1967	3,374	194	3,568	2,666 (Est.)

SOURCES: Unpublished data supplied by the Ontario College of Nurses; and the Brief of the Ontario Hospital Association to the Council on Health, 1967 (unpublished).

It can be seen that since 1965, when the major emphasis began on increasing the numbers of graduates to overcome the perceived nursing shortage (goal: 5,000 graduates per year by 1971), the increase in both enrolments and graduates up to 1967 had not been particularly striking. In fact, enrolments had actually declined slightly over the three years and the numbers of graduates increased by less than 100 per year. This was primarily the result of a relatively slow start among existing diploma and degree schools in arranging to increase existing enrolments, and of the inevitable difficulties in creating the decentralized system of regional schools first proposed in 1965. Let us examine the future by considering the expected *capacity* of nursing schools in the next few years.

TABLE 29

**Actual and Estimated Capacity of Ontario Diploma Nursing Schools
1967-1971**

School	Actual Enrolment 1966	Actual Enrolment 1967	Expected 1968	Annual Capacity 1969	Enrolment 1970	Enrolment 1971
REGIONAL SCHOOLS (Existing or planned)						
<i>Location</i>						
Barrie	46	56	70 ³	82 ¹	82	82
Belleville	—	—	—	—	70 ²	70
Brantford (no progress made in gaining acceptance of regional school. See under "2 + 1" programs)						
Brockville					80 ²	80
Cooksville	—	—	50 ³	90 ³	120 ³	150 ¹
Cornwall		89	90	90	90	90
Guelph					50 ¹	50
Hamilton and district	61	68	75	75	75	75
Kitchener (no submission for regional school received by mid-1967)						
Kirkland Lake					30 ¹	30
Lakehead (Port Arthur hospitals only. Fort William not willing to join) ²					119	119
London-Chatham		95	97	97	97	97
Oshawa (no agreement on regional school)						
Ottawa				120	150 ³	200 ¹
Owen Sound			30 ²	60	90 ¹	90
Pembroke (no submission for regional school received by mid-1967)						
St. Catharines			80	100 ³	150 ³	175 ¹
Sarnia		20	60 ³	75 ³	90 ¹	90
Sault Ste. Marie (no submission for regional school received by mid-1967)						
Stratford				70 ²	90 ¹	90
Sudbury			80 ²	100 ¹	100	100
Timmins				23 ¹	23	23
Toronto—Osler	38	55	70 ³	100 ¹	100	100
Toronto—Scarborough		40	70 ³	100 ³	160 ¹	160
Toronto—York		61	75 ³	100 ³	150 ³	200 ¹

¹Year that capacity is to be reached is approximate. For estimation purposes, it is derived by adding four years to the year of expected opening except where an existing school in the location already enrolls numbers at or near expected capacity.

²Year of opening not certain as regional school may or may not wait until new buildings have been completed. Will be earlier than estimated if school does not wait for new buildings.

³Figures based on assumed steady and regular increase from known existing enrolment or estimated initial enrolment to maximum capacity.

⁴No maximum set; estimate only.

TABLE 29 (Continued)
Actual and Estimated Capacity of Ontario Diploma Nursing Schools
1967-1971

School	Actual	Actual	Expected	Annual	Enrolment	
	Enrolment 1966	Enrolment 1967	1968	Capacity 1969	1970	1971
EXISTING 2-YEAR SCHOOLS						
Hamilton and District (see under regional schools)						
Toronto Nightingale	70	61	65	65	65	65
(no expansion planned as of 1967)						
Toronto Quo Vadis	46	42	75	75	75	75
Toronto Women's						
College	81	32	50 ³	70 ³	100 ¹	100 ¹
(Omitted: Toronto, Ryerson Polytechnical Institute)						
EXISTING 3-YEAR AND "2 + 1" SCHOOLS						
Belleville	21	32	40	60	—	—
(to merge with regional school by 1970 or sooner)						
Brantford ("2+1")	54	39	60	80 ⁴	80	80
(to expand, but no maximum set)						
Brockville ("2 + 1")	29	30	40	50		
Cornwall — General	42					
— Hotel Dieu	44					
(merged as regional school 1967)						
Guelph ("2 + 1")	36	33	40	40		
(regional school by 1970 or sooner)						
Kitchener — St. Mary's	54	45	60	60	60	60
("2 + 1")						
— St. Joseph's	35	35	35	35	35	35
— Waterloo	66	63	65	65	65	65
Lakehead — Pt. Arthur						
Gen.	42	43	42	42		
— St. Joseph's						
(Above	31	33	31	31		
two to merge as regional school)						

¹Year that capacity is to be reached is approximate. For estimation purposes, it is derived by adding four years to the year of expected opening except where an existing school in the location already enrolls numbers at or near expected capacity.

²Year of opening not certain as regional school may or may not wait until new buildings have been completed. Will be earlier than estimated if school does not wait for new buildings.

³Figures based on assumed steady and regular increase from known existing enrolment or estimated initial enrolment to maximum capacity.

⁴No maximum set; estimate only.

TABLE 29 (Continued)
Actual and Estimated Capacity of Ontario Diploma Nursing Schools
1967-1971

School	Actual Enrolment 1966	Actual Enrolment 1967	Expected 1968	Annual Capacity 1969	Enrolment 1970	Enrolment 1971
EXISTING 3-YEAR						
"2 + 1" SCHOOLS (continued)						
— McKellar	48	51	48	48	48	48
Oshawa	39	42	40	40	40	40
Ottawa — General	70	66	70			
— St. Louis- Marie	20	15	25			
(merging to regional about 1969)						
Owen Sound	—	—				
(changing to regional about 1968)						
Pembroke ("2 + 1")	34	26	20	20	20	20
St. Catharines	81	93				
(changing to regional about 1968)						
Sarnia	31					
(changed to regional 1967)						
Sault Ste. Marie						
—St. Mary's ("2+1")	45	40	45	45	45	45
—Plummer (3-year)	31	28	30	30	30	30
Stratford	22	27	40			
Sudbury — General	41	—				
— St. Joseph's	41	54				
(to merge as regional school)						
Timmins	28	33	25			
(change to regional about 1969)						
Hamilton Civic						
("2+1")	90	80	110 ³	130 ³	150 ³	170
Ottawa Civic						
("2+1")	164	173	150	150	150	150

¹Year that capacity is to be reached is approximate. For estimation purposes, it is derived by adding four years to the year of expected opening except where an existing school in the location already enrolls numbers at or near expected capacity.

²Year of opening not certain as regional school may or may not wait until new buildings have been completed. Will be earlier than estimated if school does not wait for new buildings.

³Figures based on assumed steady and regular increase from known existing enrolment or estimated initial enrolment to maximum capacity.

⁴No maximum set; estimate only.

TABLE 29 (Continued)
Actual and Estimated Capacity of Ontario Diploma Nursing Schools
1967-1971

School	Actual	Actual	Expected Annual Enrolment			
	Enrolment 1966	Enrolment 1967	Capacity 1968	1969	1970	1971
EXISTING 3-YEAR AND "2 + 1" SCHOOLS (continued)						
Toronto—General						
("2+1")	125	125	125 ³	160 ³	200	200
—St. Joseph's	85	103	123 ³	123 ³	150	150
(became 2-year program 1967)						
—Wellesley						
("2+1")	83	69	80 ³	80 ³	100 ³	100
— Western						
("2+1")	121	108	120	120	120	120
Windsor—Metropolitan						
("2+1")	27	27	40 ³	66	66	66
— Grace						
("2+1")	34	45	30	30	30	30
Woodstock ("2 + 1")	48	48	47	47	47	47
Chatham ("2 + 1")	41	43	40	40	40	40
Hamilton — St. Joseph's						
("2+1")	134	104	125	125	125	125
Kingston — General						
("2+1")	88	76	100	100	100	100
London — Victoria						
("2+1")	119	120	130	130	130	130
Niagara Falls	36	45	40	40	40	40
North Bay ("2 + 1")	43	51	40	40	40	40
Orillia	34	32	30	30	30	30
Peterborough ("2 + 1")	35	31	30	30	30	30
Toronto — St. Michael's						
("2+1")	130	95	120	120	120	120
— East General						
("2+1")	66	57	65 ³	80 ³	97	97

¹Year that capacity is to be reached is approximate. For estimation purposes, it is derived by adding four years to the year of expected opening except where an existing school in the location already enrolls numbers at or near expected capacity.

²Year of opening not certain as regional school may or may not wait until new buildings have been completed. Will be earlier than estimated if school does not wait for new buildings.

³Figures based on assumed steady and regular increase from known existing enrolment or estimated initial enrolment to maximum capacity.

⁴No maximum set; estimate only.

TABLE 29 (Continued)
Actual and Estimated Capacity of Ontario Diploma Nursing Schools
1967-1971

School	Actual	Actual	Expected	Annual	Enrolment	
	Enrolment 1966	Enrolment 1967	1968	Capacity 1969	1970	1971
EXISTING 3-YEAR AND "2 + 1" SCHOOLS (continued)						
Galt	32	34	35	35	35	35
Kingston — Hotel Dieu	61	64	69	69	69	69
Peterborough Civic	56	47	55	55	55	55
St. Thomas	54	44	51	51	51	51
Toronto — Sick Children's	64	76	60	60	60	60
— Branson	21	23	20	20	20	20
Windsor — Hotel Dieu	80	75	90 ³	100	100	100
TOTALS	3,205	3,242	3,718	4,169	4,734	4,909

¹Year that capacity is to be reached is approximate. For estimation purposes, it is derived by adding four years to the year of expected opening except where an existing school in the location already enrolls numbers at or near expected capacity.

²Year of opening not certain as regional school may or may not wait until new buildings have been completed. Will be earlier than estimated if school does not wait for new buildings.

³Figures based on assumed steady and regular increase from known existing enrolment or estimated initial enrolment to maximum capacity.

⁴No maximum set; estimate only.

SOURCE: Author's own extrapolations and estimates based on unpublished information provided by OHSC.

Table 29 is a crude but, we believe, conservative estimate of the capacity of diploma schools to enroll students between 1966 and 1971. It is derived from a progress report on nursing schools prepared for internal use by consultants within the OHSC. The estimates are conservative in that they do not include the university degree programs, or Ryerson Polytechnical Institute (an entirely independent two-year program), or the schools attached to three Ontario government mental hospitals. If one added the estimated capacities of these schools to the totals, they would add about 340 students in 1968 and up to at least 1,100 more by 1971, given that the university and other programs expand as planned by that time. The estimates in Table 29 also do *not* include planned increases in enrolments for proposed regional schools which had not at the time of writing started to form; nor are increases in enrolments in existing schools included unless some concrete plans to attain the increase had been made at the time of writing and implementation of them had already begun.

On the other hand, a few assumptions have been made which a pessimist might call unrealistic. It is assumed that the regional schools which have

been formed will carry on to actually construct the buildings they need, and will obtain the necessary staff and clinical facilities to support their planned maximum enrolments. Similarly, existing schools planning to expand are assumed to be successful in acquiring additional space, budget and staff to complete their expansion.

If one assumes that the schools listed in Table 29, plus university schools and those mentioned above which are not listed, will have the capacity to enroll about 4,100 students by 1968, 4,800 by 1968, and 6,000 students by 1971, this still does not indicate the number of graduates. For one thing, it is not at all clear that enough qualified applicants will be found to fill all existing places; in addition, one must allow for an average drop-out rate of 20 per cent for each year's class before it graduates. For example, assume that 4,100 students are actually enrolled in 1968. The vast majority of these will be in two-year or "two plus one" programs, so that they will be working practically full time after two years. (Even three-year program students spend most of their last year giving service.) If 20 per cent drop out, this means an addition of about 3,300 qualified or *almost*-qualified nurses to the labour force by 1970. An actual enrolment of 4,800 by 1969 will yield about 3,800 more nurses or full-time working students by 1971. This is still a far cry from the hoped-for 5,000, but a considerable improvement over the present 2,500 graduates. Whether this is too many, too few, or just right depends on how one views the confused supply and demand picture described in Chapter 4.

The most crucial variables determining the success of current efforts and plans to increase the numbers of diploma nurse graduates are availability of applicants; availability of teaching staff; and, of course, the speed of the various schools in getting themselves organized, and the rapidity with which they acquire their physical plant and other facilities.

Recruitment of Students

Diploma School Recruitment

From 1946 to 1962 a mildly fluctuating but generally increasing percentage of the female population of Ontario between the ages of seventeen and nineteen enrolled in the province's nursing schools. It rose from 4.36 per cent to a high of 6.04 per cent in 1956 and 6.01 per cent in 1962. Between 1957 and 1959, the percentage decreased slightly and it has been decreasing since 1963, though it still has not fallen as low as the proportions in the immediate post-Second World War years.¹ In general, between 1946 and 1964 enrolment in nursing schools tended to keep pace with the growing population of the province (as measured by the ratio of student nurses to population). One study thus concludes: "The fact that the rate of increase in student nurses is apparently keeping pace with

¹"Further Estimates of the Future Enrolment of Students in the Schools of Nursing in Ontario, 1965-1975", Medical Statistics Branch, Ontario Department of Health, January 1965, p. 4.

the rate of increase in the general population suggests that estimates based on the assumption that this rate of increase in the student nurse enrolment will continue may well be the most useful in planning for the future.”²

If we turn from longitudinal studies of past enrolment figures to the recent past, it can be seen from Table 28 that the 1967 actual enrolment declined from the previous year in spite of strenuous efforts to increase it. It is impossible to state whether this is because of a shortage of applicants or a shortage of places in the schools due to problems of switching from a three-year to a “two plus one” curriculum planning expansion, or because of mergers with other schools into regional schools. All three time-consuming activities were certainly going on in a large number of schools during the 1966-1967 academic year.

The enrolment figures for 1967 compared to 1966 show that thirty-two schools dropped in enrolments from the previous year while at least thirty-four increased, resulting in a net decline of sixty-four persons. One of the reasons for this, as mentioned, could be the upheaval caused by changing from a three-year to “two plus one”, from “two plus one” to two-year, or from single to regional school. Another possible explanation is staff shortages. Going over the list of schools with the help of College of Nurses officials, we could establish that nine schools which showed declining enrolments were in the throes of change in 1966-1967 and four more were known to be complaining of a staff shortage. For the remaining nineteen, neither of these explanations applied. Unfortunately all the “unexplainable” schools were among those we did not personally visit, and there was no time to get in touch with them to discuss the matter.

Among the thirteen schools of nursing the researchers *did* visit during the summer of 1967, none complained at that time of a shortage of qualified applicants to fill their available openings.

One problem which did become apparent in the course of our visits, however, was the system for processing applications. This system is such that a school may accept a qualified applicant who then fails to appear for registration, thus causing an unfilled opening; or it may reject an applicant that another school might consider favourably. It is not known how many students apply to more than one nursing school, but it is certain that some students do. The usual procedure in most schools contains no check on this, nor is there in most schools any requirement that a student notify a school if she decides not to attend after being accepted.

What is needed ideally is a centralized and computerized system to keep track of all applicants. Such a system could inform schools which have accepted an applicant whether or not she has chosen to attend; schools could also take applications from applicants with minimum qualifications who have been rejected by the school of their first choice, and send them to schools which have less stringent

²*Ibid.*, p. 10.

admission requirements. In this way, every aspiring nurse could be sure to get every possible chance of being admitted; and unfilled openings due to "no shows" by people applying to and being accepted by several schools could be avoided. Such a system would operate as follows:

- 1) A standard application form would be devised.
- 2) Applicants would apply to individual schools as in the past.
- 3) The school would decide on the applicant.
- 4) Provided she met the minimum qualifications laid down in the Nurses' Act, a copy of the applicant's form would be sent to the centralized information centre.
- 5) Applicants accepted by their first choice school would be required, within a specified period, to inform the central bureau whether or not they would attend the school. Forms from applicants who were rejected but still minimally qualified would be sent by the central bureau to schools with openings and possessing less stringent standards.
- 6) Each school would be notified continuously of applicants who accepted their offer of admission.
- 7) Central records would keep running tallies on how many openings each school had left so as to allow even last minute applicants a chance to get in somewhere.

The list of explanations for the current decline or slow growth of nursing enrolments includes lags in changeovers and expansions, staff shortages, and faults in the application processing system within nursing schools. Not yet mentioned is the possibility of nursing simply declining in popularity among young women today. Although it is not certain that this is in fact the case, reasons for this could include the following: confusion about the nature and purpose of modern nursing inferred from the blurred image created by the profession itself; dislike for the wages relative to hours, shifts and other working conditions; the comparative attraction of work and working conditions in other occupations; growing ability to afford and increased desire to attend university or other post-secondary educational institutions.

While it is possible that the above factors cause more girls than previously to shun a nursing career, it is not at all certain as yet whether there are, therefore, not enough girls *remaining* who are amenable to persuasion to enter nursing. It might well be that although there are larger numbers of disaffected potential recruits, there are still more than enough who could be attracted into nursing if approached properly. One reason that one cannot infer that the potential pool of recruits is dry is that, by and large, recruiting campaigns for the profession are far, far short of what they could be.

The RNAO, the OHA and individual hospitals do what they can in the way of publishing pamphlets on nursing as a career, disseminating information on nursing schools, and providing speakers for high school audiences. They have not the time, money or professional know-how, however, to mount major public relations campaigns or to try to develop as yet relatively untapped sources of recruits among older women and males. At least one reason why there are no large-scale recruiting programs aimed at "new" sources of supply, such as males or older women, is primarily that there are very few programs tailored to their needs and values. The fact that the efforts that are made are not at all coordinated with one another does not help either. Finally, many of the key figures in shaping students' vocational choices — high school guidance counsellors and students' parents — are ignorant or confused regarding the nature of modern nursing and the differences among various types of nursing education programs. That this is not all their fault is clear when one examines press clippings over the past few years dealing with the nursing profession.³

Recruitment into Degree Programs

Directors of university degree programs to whom we spoke maintained that there was no difficulty in obtaining adequate numbers of applicants for the four-year integrated baccalaureate programs, given their present capacities. They did admit, however, that since lengthening the baccalaureate program for diploma-trained R.N.'s from two years to three, there has been a decline in applications due to the usually self-supporting women who make up the bulk of the potential entrants not wanting to take more than two years away from their work. This problem is aggravated by the current system of provincial aid for these students. At present an unlimited number of bursaries is available from the Department of Health for R.N.'s wishing to proceed towards a degree. They are given for two years and provide \$175 per month during the academic year, as well as covering the cost of tuition. In return, a bursary holder agrees to give one year of nursing service in Ontario for each year of bursary support. The problem, of course, is that with the extension of the baccalaureate program for diploma R.N.'s to three years, the student must finance one full year of her studies herself.

When it comes to applicants for Master's degrees at the one university offering these, there is also no surplus of candidates. In fact, for the 1967-1968 academic year it appeared that the university might have been able to handle a few more M.Sc. students than it obtained.

As yet there are no indications that the universities are considering means for making it any easier for diploma-trained R.N.'s to obtain Bachelor's or Master's degrees. In fact, with the lengthening of the R.N.-Bachelor's program and the

³The whole area of recruiting for diploma nursing is thoroughly treated in R. A. H. Robson, *Sociological Factors Affecting Recruitment into the Nursing Profession*, Royal Commission on Health Services, Queen's Printer, Ottawa, 1964.

slow elimination of one-year certificate programs, it is undoubtedly more difficult than ever before for a woman with her R.N. from a diploma school to progress beyond this. Hopefully, when the faculty resources of the university nursing schools improve, the schools will no longer be forced to choose between basic degree and post-R.N. degree programs and will be able to introduce new measures to increase the enrolment of existing R.N.'s. Such measures as night programs, special spring and summer sessions, or work-study programs undoubtedly would offset the declining enrolment among this important segment of potential university degree students.

Staff Recruitment

Diploma School Staff

Everyone we spoke to with any interest in and knowledge about nursing today — whether employers, nursing administrators or educators — agreed that there was a serious shortage of staff to teach nurses. Where they differ in viewpoint is in the source of supply for teachers. Most educators feel that experience and a Bachelor's degree are the minimum qualifications for a teacher in diploma nursing schools; other nursing spokesmen are content with the present legal qualifications of two years' experience plus one year of university; and many employers feel that nursing experience alone is adequate, if the person is the "right type" for teaching and is helped to pick up the pedagogical tricks of the trade on the job.

Although there may be just barely enough teachers at present to maintain the current ten to one student:teacher ratio in the province, the problem lies with the large program of expansion of diploma education planned for the next four or five years. Already four or five schools have indicated that their only restraint from expansion is lack of qualified staff, and one cannot help wondering where the staff for large new regional schools will come from once they start opening at a fast rate between 1969 and 1971. The whole matter needs very careful study and rapid action.

In theory, as schools switch from courses that are three years to "two plus one" or two years in length, fewer teachers should be needed, as the third year is eliminated or turns into a "plus one" year controlled largely by service personnel. Thus, if a total of 5,500 students enrolls in all Ontario nursing schools in 1970 and requires instruction by qualified teachers for *two* years only, this would mean a total student enrolment of around 10,000 "studying" students (allowing for a 15 per cent attrition rate and a slightly smaller enrolment from the previous year). In 1966 approximately 960 teachers were in charge of about 9,000 students; therefore, by one superficial reckoning, to maintain the same ratio as 1966, only forty additional teachers would be needed by 1970 because of dropping the third year controlled by teachers. This reasoning is misleading, however, since in 1966 at least 50 per cent of the students were *already* in two-year or "two plus one" programs and thus required only two years of instruction by teaching staff. To make

the 1970 projections more nearly comparable, therefore, one should take one-third off the 4,500 students who were de facto two-year students in 1966, thus leaving 960 teachers to teach about 7,500 students actually requiring instructors — a ratio of 1:7.8. Using *this* more realistic ratio, the estimated total of 10,000 students in 1970 will need about 1,280 teachers, or nearly 300 more than are now available. Crude though this estimate is, it is probably a very conservative one since it takes no account of teachers needed for expanded in-service training programs or RNA programs.

The university degree programs produce about 200 graduates a year at present. Only part of this group is willing to teach and all must acquire at least two years' experience before doing so. The one-year certificate programs for teachers are almost gone. Obviously, therefore, the supply of newly prepared teachers could not possibly be adequate to supply the need by 1970. Where else can teachers be obtained?

- 1) The most popular source at present is probably to "raid" schools outside the province. There are definite upper limits to this practice, however.
- 2) Another source is present degree-holders with nursing experience who are now not teaching or not working at all. They might prove serviceable if they could be located, persuaded to teach, and given a short refresher program in teaching.
- 3) Another source is non-nurse teachers in universities, or community colleges, able to teach basic health-related sciences, social science or medical subjects to nurses. Such non-nurse instructors are already being used in a limited way in a number of schools located near the sources of such personnel. No doubt such instructional resources could be exploited more fully.
- 4) A fourth source is "unqualified" nursing personnel who could act as assistants to teachers, aiding them with certain laboratories or with the supervision of certain kinds of clinical experience. Previous experience with this approach is discussed in Chapter 10.
- 5) Finally, it may be possible to make existing teachers more effective and able to handle more students by finding ways to relieve them of activities which could be carried out by clerical staff.

In any case, there is no question that a "crash program" to determine the exact nature and size of the expected teacher shortage and to study means for meeting it is very badly needed, if the expanded diploma educational system already embarked upon in the province is to function without incurring reduced standards of instruction. Such a program would have to go on above and beyond continuing efforts to increase the numbers of baccalaureate nurses to supply teaching needs beyond 1971.

University Faculty

If one considers the future supply of teachers for diploma schools seriously deficient, the situation with regard to qualified faculty for university nursing schools is even worse. Given that a university degree is part of the minimum requirement for a diploma school teacher, and that an M.Sc. is one of the minimum qualifications for university faculty, the sad fact is that only the merest handful of Master's graduates are produced in Ontario each year, and of these a very few are willing and competent to teach at the university level. As for the Ph.D. degree (the *desired* minimum qualification for faculty in most universities), it is obtainable only abroad. Of the few who leave to start Ph.D. studies each year, the majority do not finish; others do not return to Ontario; still others choose not to join universities. The net increase in nursing Ph.D.'s per year in the past few years is between one and three.

To *begin* the process which ultimately leads to more diploma school graduates, therefore, university nursing schools must be made attractive to Ph.D. and other qualified faculty now outside Ontario by virtue of unusually favourable salaries, teaching loads, research facilities and support, and healthy graduate programs at the Master's level. This will eventually attract more Master's students who will spread out to younger and smaller university schools as faculty. The enlarged and enriched university nursing facilities will then be in a position to handle more baccalaureate students who, in turn, will form the source of supply for diploma school staff enabling these schools to handle the enrolments expected of them.

Opinion on Quantity of Education

Most of the debate of relevance to quantity centres around control of schools and how to resolve conflicts between meeting immediate needs for numbers while not sacrificing — but while, in fact, improving — quality. These divergent views of how to achieve quantity and quality will be discussed in Chapter 9.

Suffice it to say here that virtually all parties with an interest in nursing agree that there is a need for more students, more diploma graduates, and especially more baccalaureate and postgraduate degree-holders.

Chapter 8 Education for the R.N.A. and Other Nursing Classifications

Current Conditions

As with virtually all the other issues in nursing discussed so far, the situation with regard to the education of those who give nursing care but are not registered nurses is overlooked relative to that of R.N.'s. It is not debated, publicized, or extensively studied. For that reason, the data on the current and expected future situation in education for this group are far from adequate.

R.N.A. Education

Basic Forms of R.N.A. Education

In 1967 there were forty-nine centres in Ontario approved by the College of Nurses for the training of registered nursing assistants. Hospitals contain the majority, thirty-four; eleven are situated in public secondary schools; and six are operated directly by the provincial government Department of Health under its Special Health Services Branch. They are well distributed throughout the province in approximate proportion to the density of population and health services.

Until mid-1967, R.N.A. training took the equivalent of about forty weeks or ten months of instruction; but this time was distributed in a variety of ways, depending on whether the program was controlled by hospitals, high schools or the Department of Health. Hospital-based programs ran for forty weeks with the equivalent of five days per week in most cases; three of the Department of Health courses and one high school-based program were also of this type. The Department of Health offered as well an evening program for R.N.A.'s, which ran for twelve months but required approximately the same number of hours of instruction and practice. The high school-based program comprised 50 per cent regular high school courses and 50 per cent nursing assistant instruction and practice, integrated over grades 11 and 12; so that, again, the total amount of specific nursing assistant training was about ten months. (Incidentally, it should be noted here that the Department of Health offers one R.N.A. program per year for males only — thus making it the only formal nursing training program in the province which actively encourages male enrolment.)

In August 1967, the Regulations of the Nurses' Act were amended to read: "The instruction and experience prescribed by Clause C (outlining content of the

program) are provided by the training centre over a period of 35 weeks" (Section 24 (d)). While the College of Nurses has no objection to individual *diploma* nursing schools offering programs beyond the minimum length and, until the above amendment, did not object to R.N.A. programs extending slightly beyond forty weeks, they are *now* apparently interpreting this clause of the regulation to mean that R.N.A. programs *must* reduce their length. Accordingly, the Department of Health program, for example, has been cut to thirty-six weeks, of which one week is a vacation. Twelve weeks are now spent in the classroom phase of the program and twenty-four in the hospital experience phase. It is not clear how the College will enforce the regulation for high school programs, since they extend over two academic years. Presumably the reduction would have to be effected in the non-academic areas of the program, with the additional time given to academic subjects.

Quality of R.N.A. Education

1) Types of Programs

As with education for R.N.'s, the College of Nurses has incorporated a minimum curriculum for R.N.A.'s into the Regulations of the Nurses' Act, and inspectors within the College attempt to ensure that all training centres meet it. While each major type of program meets the minimum requirements, it does so in its own way. (The descriptions below, while in the present tense, do *not* reflect the modifications in length made as a result of the 1967 amendments to the Nurses' Act.)

Department of Health programs are divided into two main units. Unit 1 consists of three and a half to four months during which are taught elementary nursing, biology, relationships, nursing in emergency, hygiene and nutrition. Unit II is the "hospital period" lasting six to six and a half months for thirty-five hours per five-day week. Subjects taught are medical, surgical, obstetrical and paediatric nursing skills for nursing assistants.

Hospital-operated programs. Unfortunately we did not have an opportunity to study at length the registered nursing assistant programs in the various hospitals we visited. It was our impression from discussions with people familiar with these programs, however, that there might be considerable variation in the kind of "theory" given in the first part of the program in terms of the way courses are structured and the depth and variety of content beyond required minima, but a fairly high degree of uniformity in the basic nursing practice subjects. Where the practical instruction does vary slightly is in the case where the particular hospital has authorized its R.N.A.'s to perform some procedure not usually done by this group, such as taking blood pressures. Instruction in such procedures is then included in the basic R.N.A. program. As one example of a hospital-operated program, the Committee on the Healing Arts obtained information on the R.N.A. program at St. Michael's Hospital, Toronto. The first "semester", fourteen weeks in length, is primarily "theory" on the following subjects: anatomy and physiology;

ethics; fundamentals of elementary nursing; growth and development; hygiene and nutrition. The second semester of thirty weeks covers the theory in child care; civil defence; first aid; fundamentals of elementary nursing (continued); maternal care; medical-surgical nursing and vocational adjustments, followed by clinical practice in obstetric, paediatric, medical and surgical nursing.

High school-operated programs. These have been set up with a curriculum centrally developed by the Department of Education in close cooperation with experts in the Department of Health and the College of Nurses. The program comprises about 50 per cent academic and 50 per cent nursing education. Special effort has been made to adapt the academic content so as to make it meaningful and relevant to nursing students—for example, in home economics, physics, chemistry and mathematics examples and applications of the theory and principles of these subjects are presented in the context of health care problems. In addition to the above subjects, the students may take English, history, economics or physical education as part of their academic stream throughout grades 11 and 12. For the remaining two and a half days a week during this time, they study nursing theory and practice having to do with fundamental nursing skills in relation to specific types of patient and areas of illness. The nursing “theory” is presented mainly in grade 11 and clinical experience is acquired in grade 12, made up of about five weeks in medical and surgical units and four weeks on paediatrics and obstetrics.

Interestingly enough, one does not encounter raging debates in the press, in journals, or among interested individuals about the relative “goodness” of hospital versus high school versus Department of Health programs; nor are there any emotional upheavals over the amount of theory versus the amount of practice, or what the depth and breadth of non-clinical subjects should be. On the whole, the subject of R.N.A. education is treated much more calmly, though this is not to say there is no criticism or desire for improvement.

There is considerable concern, for example, over the adequacy of clinical facilities, especially in the obstetric and paediatric areas. The high school-based programs in particular seem to have difficulty arranging sufficient affiliations with hospitals for these areas. Similarly, there is some feeling that the R.N.A. student should obtain, as part of her required program, more instruction in the nursing of long-term and chronically ill patients, both because of a very real shortage of trained staff for this type of patient and because of a belief that such people represent an important special area of nursing to which every nurse should be exposed as part of her basic training. Another of the 1967 amendments to the Regulations of the Nurses’ Act may have the effect of bringing about the latter improvement. Required clinical practice is now defined in terms of patient age groupings rather than clinical specialties. Also, the Department of Health has recently launched a special training program to emphasize chronic care nursing.

2) *Standards for Participation in R.N.A. Training*

The academic standard of admission for students into the R.N.A. program has been increased over the years since this class of nurse was created shortly after World War II. It is now grade 10 from either the four or five-year stream in high school, plus a minimum age qualification of seventeen years. In fact, in 1966 out of 768 nursing assistant students enrolled, 420 had grade 10, eighty-six had grade 11, and 262 had grade 12 or better.

There are no existing studies on attrition rates in R.N.A. programs; hence we have no firm knowledge of how many drop out for academic reasons. It is the belief of several people we interviewed who are familiar with R.N.A. training programs that the situation is little different from that described for diploma students in the previous section. For example, the drop-out rate for day students in the Department of Health programs in 1967 was 18 per cent. Also we do know that failure rates on the R.N.A. examinations conducted by the College of Nurses are similar to those for R.N. students.

In the case of R.N.A. program *teachers*, there is no minimum requirement laid down by the Nurses' Act other than that the *director* of the R.N.A. training centre be a registered nurse. In fact, this is interpreted to mean that the R.N. is the minimum requirement for *all* instructors in training centres as well. Though, again, there are no figures breaking down the R.N.A. instructors by qualification, it is believed that perhaps a quarter possess qualifications beyond the R.N. diploma. In the Department of Health R.N.A. programs, for example, of the fifty-two instructors, eight have a university degree and sixteen possess one of the one-year certificates, mostly in the teaching specialty. All teachers in the ten high school-based programs must both have R.N. standing *and* be "qualified secondary school teachers".

Generally speaking, the ratio of one instructor for every ten R.N.A. students appears to hold in Ontario, although, of course, there are variations from this from one centre to another as in the case of R.N. diploma schools.

Quantity of R.N.A. Education

Table 30 shows the number of nursing assistant training centre graduates registering with the College of Nurses from 1963 to 1966.

TABLE 30
Graduates from Nursing Assistant Training Centres Registered by the
College of Nurses, Ontario — 1963-1966

Program	1963	1964	1965	1966	Total
Hospital-operated	633	613	669	654	2,569
High school-based	30	36	65	98	229
Department of Health-operated	471	557	412	540	1,980
Totals	1,134	1,206	1,146	1,292	4,778

It can be seen from this table that, similar to the situation for R.N.'s, the number of graduates has not been increasing by large numbers over recent years. The provincial government's recently set objective of 2,000 R.N.A. graduates per year by 1971 is not being achieved any more rapidly than the "5,000 R.N. graduate" objective. The Department of Health is now moving rapidly to expand enrolments in its own training centres. It turned out 608 graduates in 1967 and is aiming for 900 graduating by 1970 by means of increasing the number of new classes begun each year and adding new training centres. The primary inhibition to expansion of all types of programs is the procurement of sufficient clinical facilities.

As far as we could tell, there are no serious problems as yet in finding adequate numbers of recruits to apply for the available positions in the R.N.A. training programs. Nor does there appear to be any shortage of minimally qualified people to teach the program. These statements reflect only the impressions of a few people involved in R.N.A. education, however, and they are the first to state that detailed studies of R.N.A. education from the point of view of both quality and quantity are needed.

Education for Other Nursing Classifications

It is not intended to describe in detail the educational preparation for the various classes of practical nurses who provide a great deal of nursing care to the sick outside hospitals in nursing and convalescent homes, as well as in other settings. The vast proportion of such training as these people receive is on-the-job and hence would range in quality from abysmal to possibly as good as that of an R.N.A. There is at least one formal program for practical nurses which operates privately in Toronto; it claims to provide an education "as good as or better than that given to R.N.A.'s". Curiously, although nursing officials are delighted to encourage R.N. programs to be completely independent of control by hospitals or other official bodies, the director of this "independent" practical nurses' school — who would very much like the school to have status as an official R.N.A. training centre — claims he cannot get the College of Nurses to visit his premises or otherwise give constructive criticism concerning what his school must do to earn accreditation. No doubt part of his difficulty arises from not having access to any hospital-based clinical facilities.

As pointed out in Chapter 2, the nature of the work of most unqualified nursing personnel outside hospitals is largely very routine physical care given to types of patients that most qualified nurses avoid if they can. The dangers inherent in their variable, but generally low standard, level of preparation lies in the possibility of being grossly undersupervised by qualified personnel, or being given responsibility for carrying out complex nursing procedures, or having to observe seriously ill patients.

In the case of nurse's aides and orderlies *in* hospitals, the situation is somewhat better than for practical nurses outside. Since the supervision is more plentiful and more skilled, the probability of committing a major error is much less. Similarly, the tasks of most aides and orderlies vis-à-vis the patient are quite simple and routine. As a result, adequate training is provided through on-the-job instruction and "learning by experience". This arrangement becomes unsatisfactory when aides and orderlies are required to perform tasks or assume responsibilities beyond their level of preparation and without proper supervision. Such situations arise during periods of temporary shortage of formally trained R.N.'s or R.N.A.'s or in specific hospitals which, for one reason or another — their location, type of patient cared for, or poor reputation — experience long-term or chronic staff shortages.

Particularly vulnerable to the dangers of too much responsibility coupled with too little supervision are hospital orderlies. Lingering social folkways which cause male patients to become upset at having female nurses see or carry out procedures in or around the genital area of the body result in many of these procedures being performed by orderlies; these men also perform duties involving the movement of patients which are too arduous for female nurses. In the case of orderlies who have had nothing but haphazard on-the-job training and may also have little in the way of previous background or aptitude to facilitate learning, their performance of such nursing duties is potentially dangerous to patient welfare.

There is a growing trend in Ontario hospitals to separate orderlies into two groups — those who give patient care and those who perform primarily house-keeping functions — and to provide a formal program of in-service training for the former. A few hospitals apply this dichotomy to the nurse's aides as well. The nature and extent of this formal in-service training is dependent on the type of work expected of the trained orderly or aide, and also on the availability of qualified staff, facilities for providing training, and the severity of the shortage of hands on the wards. An extreme shortage of personnel often means available orderlies and aides cannot be released long enough to attend class.

Since there is no centralized control or evaluation of in-service training programs, it is not known how many hospitals provide formal instruction for their non-registered nursing staff, or how "good" or "poor" this training is among those who do offer it. From our field visits in hospitals providing training, it appeared to range from a level which approximates that provided for R.N.A.'s to little better than a job-orientation program of a few hours a day for three or four weeks.

Opinion on Education for the R.N.A. and Other Nursing Personnel

As already indicated, the most noteworthy feature of the reaction of groups and individuals concerned with nursing to anything having to do with R.N.A.'s and others is that there is so little of it and it is so mild. Leaders among the professional nurses seem to like to pretend that R.N.A.'s do not exist, or indicate that

they wish they would somehow disappear. Most R.N.'s are given little or no instruction during their training regarding what R.N.A.'s can do or how the R.N. should relate to the R.N.A. R.N.A.'s or their spokesmen are only minimally consulted in arriving at decisions concerning their education or the nature of their practice. The only explicit opinion offered by spokesmen for registered nurses seems to be that, in the long run, the R.N.A. classification should be abolished, with the better ones moving up to R.N. level and the poorer ones dropping down to the ward aide or housekeeper classification.¹ Details on precisely why R.N.A.'s should be done away with are difficult to come by.

Among spokesmen for hospitals there appears to be a preference for the status quo concerning the quality of R.N.A. education, coupled with a strong belief in the need for a greater quantity of R.N.A. training centre graduates.

Regarding the situation for the training of orderlies and aides, there is, if anything, less concern among all relevant parties at the provincial level than there is over R.N.A. education. They seem to be the truly forgotten people in nursing.

¹See, for example, University of Toronto School of Nursing Brief to the Committee on the Healing Arts, November 1966, p. 7.

Chapter 9 In-Service Training in Nursing

The Potential Contribution of In-Service Training

The reason for including these few comments on the state of in-service training for nursing as a separate chapter rather than as a section in another chapter is simply to emphasize what we consider to be a very important and neglected area of nursing education.

From the results of our study presented so far, the kinds of problems to which in-service education for nurses could make a significant contribution can be seen to be the following.

Orientation Training

Though all new employees in an organization benefit from a formal orientation program which informs them of such matters as the specific rules, regulations, procedures, policies, goals, layout, employee benefits and services of the organization, there are some employees who need more orientation than others. Typical examples among nurses are newly arrived immigrants from countries or regions where nursing is practised slightly differently; and retired nurses returning to practice after several years of inactivity.

"Proficiency Practice" for New Diploma Graduates

If it is true that graduates from two-year diploma or four-year integrated university programs need several months of practice before they are able to function on a par with regular staff or new graduates from programs with a much longer service component, their proficiency could be more rapidly and effectively increased by means of an in-service educational program tailored specifically for them. Such a special program for the two-year graduates would ensure that they obtained both the opportunity to perform those procedures most needing practice and the experience of assuming the full burden of authority and responsibility under controlled conditions. A planned, formal program also would increase the likelihood that the guidance and instruction received was of uniformly high quality rather than variable from one unit to another.

Training in Clinical Specialization

If it is true that medical technology and associated care and cure procedures are becoming more complex and specialized over the years (as both physicians and nursing leaders assure us it is) and if the role of the nurse in aiding in the implementation of these specialized procedures is expected to increase as most physicians and some nurses hope it will, then a thorough program or set of programs

to prepare clinical specialists in nursing has to be provided by the hospitals and other employing agencies. Furthermore, if the medical care and treatment of certain types of illness in certain types of people is becoming more complex, it is also true that the degree of cooperation and coordination required between the various members of the medical team is increasing greatly. For this reason, part of the preparation of clinical specialists in hospitals should probably be on a *team* basis with doctors, R.N.'s, R.N.A.'s, laboratory, and other related personnel *all* participating. The idea of discrete little programs for one group only, such as R.N.'s, should be fading out.

Management Training

As hospitals and other health agencies are studied more and more extensively by social scientists, consultants and expert administrators, there is increasing awareness of the impact of organization structure and management skills on the severity of such administrative problems as inability to perceive needs for change; resistance to new ideas; poor communication and coordination; and employee productivity, satisfaction and turnover. As a result, there is a growing desire for first-class training in organization and management at all levels of administration from head nurse or first-line department supervisor to the top of the organization. A well-staffed, fully qualified in-service development group in the organization can spot areas of management needing training and either provide such training themselves or arrange for others to provide it. In other words, they can act as change agents in the management hierarchy.

Problems in In-Service Training Today

If the above represents the major areas in which in-service education could make a potential contribution to the improvement of nursing care, let us contrast this ideal state to the current situation as we found it in our field visits in 1967.

Most hospitals offer some sort of in-service education to their employees; however, in the vast majority of cases, the training function is fractionated, understaffed, underbudgeted, without adequate facilities and poorly accepted within the organization.

Considering the interdependence of the medical team in a hospital, for example, one would expect to find an integrated and cooperative in-service education group acting as a distinct unit within the organization. Instead, those in-service training specialists who are employed work alone, attached to the functional specialty they represent, and rarely work with their counterparts in other departments. Thus, the group handling nurses has no connection with groups providing training for physicians, or housekeepers, or laboratory personnel.

In the case of in-service education for nurses, the best hospitals are able to manage the mounting of general orientation programs for new staff (of all types)

and perhaps certain special programs for training selected R.N.'s in new procedures authorized by the medical staff. They may also oversee a basic training program for orderlies and aides and, in a few hospitals, arrange for selected R.N.A.'s to be trained in one or two new procedures not included in their basic training. Broader forms of specialized training — such as chronic illness nursing, operating room nursing — are organized and given, if at all, by the nursing unit concerned. In-service education directors may be given also a variety of routine personnel functions to perform, such as interviewing in-coming or departing staff or supervising performance appraisal programs. Very few hospitals have adequate staff to provide special orientation for immigrants, "long-out-of-practice" nurses, or new graduates and even fewer are able to mount a comprehensive management development program for nursing supervisors or others. (The closest thing available in this line is short courses or conferences given outside the organization to which some supervisors may be sent.)

Those filling the position of in-service training director are often experienced, well-educated and energetic people who sorely feel the need for specialized training in the complex area of in-service education. Unfortunately, there is very little available in this country or the U.S.A. on this subject, and it is hardly touched upon in the basic university degree programs.

The current financial formulae for hospitals and other health agencies appear to make no explicit allowance for the cost of an organization-wide in-service education department per se. The costs of whatever education is provided are somehow included among those for the department for which the program is given. In addition, the *facilities* for such educational programs in most hospitals are small or non-existent. Meeting rooms, classrooms, and laboratory, audiovisual and other teaching equipment appear to be in short supply unless there is a nursing school attached to the hospital.

Finally, many of the plans or programs for in-service training are doomed to failure in the organization because of lack of appreciation of the need for them by the various department heads and others who decide who and how many of their staff may attend a given program, and whose cooperation is sometimes needed in developing or presenting it. As a result, too few or the wrong people are released to participate, and the program itself may be of low quality.

For all the above reasons, therefore, the current quantity and quality of in-service education for nurses in major employing agencies in Ontario is far less than it could be and should be. It *could* form the basis for improving nursing administration, enhancing interdepartmental cooperation, and significantly upgrading the effectiveness of all rank-and-file employees. At present, it is unable to make a major contribution to the achievement of any of these goals.

Chapter 10 The Structure and Process of Decision-Making in Nursing Education

This chapter is organized in three parts:

- 1) The main problems and issues of debate in education as revealed in the preceding three chapters are listed.
- 2) The present basis for arriving at decisions on these matters is described along with our understanding of the influences which shape these decisions.
- 3) General weaknesses in the present system of decision-making as seen by various interested parties are very briefly discussed.

Problems and Issues in Nursing Education — a Summary

It should be noted that not all the areas of education listed below are in fact considered as problems or even issues by everyone concerned with nursing. All of them have been so designated, however, by at least *some* authoritative sources or have been judged by us to be problems as a result of our earlier research and study.

Variation in Quality of Education

Overall length of program (within R.N. diploma and R.N.A. levels). Although virtually all nursing educators agree that satisfactory nurses can be produced in two years “under the right conditions” and with perhaps “a little bit of experience” after graduation, and although existing studies of two-year programs seem to support their contention, some doctors and hospital authorities nevertheless are not yet convinced. Currently two-year, “two plus one” and three-year programs are offered.

Much to the consternation of educators connected with R.N.A. training programs, the length of these has been arbitrarily cut from forty weeks to thirty-five. From what we could gather, no studies or even discussions with leading R.N.A. educators or practitioners preceded this change on the part of the College of Nurses.

Subjects studied (within R.N. diploma and degree levels, diploma schools, and universities) vary widely on whether they include instruction in such areas as team nursing, operating room nursing, dietetics and certain social sciences such as medical sociology. Among those subjects taught there is variation in the depth

and breadth of coverage, and degree of integration with and relevance to the practice of nursing. Educators take differing stands on all these matters. Plentiful and high quality research on the value of various curricula is lacking.

Clinical facilities (R.N.A., R.N. diploma and degree levels). Some schools and R.N.A. training centres are having difficulties in obtaining sufficient clinical learning experiences for their students in various areas such as public health, obstetrics and paediatrics. Others are unhappy with the quality of experiences obtained — for example, they may be too simple or not provide enough variety.

Amount of experience in nursing actual patients or clients (R.N.A., R.N. diploma levels). This is partly an extension of the controversy over shortened R.N.A. programs and the two-year versus three-year length of R.N. diploma programs. Within two-year diploma programs, however, there is also debate on how much of the total time should be spent on nursing practice with actual patients.

Teaching aids and special facilities (all levels). Schools vary in their knowledge and/or possession of various kinds of teaching aids, and classroom and laboratory space and equipment.

Student-teacher interaction (R.N. diploma level). Schools vary in both the quantity and quality of the upward communication from students. Most nursing educators feel that a low level of attention to individuals and unilateral communication downwards is no longer acceptable for any form of post-secondary education.

Student:teacher ratios (R.N. diploma). Schools vary considerably in the number of students per full-time teacher. When ratios are too high, most educators feel there will be inadequate attention to individual students, and this, in turn, seriously affects their acquisition of nursing skills.

Faculty qualifications (R.N. diploma, R.N. degree). Most educators feel that a B.Sc. is the minimum qualification for diploma-level teachers and the M.Sc. is minimal for Bachelor's degree-level teachers. They contend that too many schools have too few teachers with even the minimal qualification. Some hospital authorities argue that, in the light of the teacher shortage, there should be no legal requirement at all in the way of formal academic qualifications for diploma-level teachers beyond the basic R.N. qualification.

Admission standards (R.N. diploma level). Schools vary considerably on how far beyond the minimum legal academic requirements they expect applicants to have progressed before they are acceptable to the school.

Staff, money, facilities and support for all types of in-service education. Only a very few hospitals and even fewer other employers of nurses have anything like a systematic comprehensive program for employee development for management

personnel; "special" types of new employees (immigrants, retired, graduates needing experience); or employees needing clinical specialization. With the ever-increasing size, complexity and interdependence of health service agencies and all types of health service personnel, this is an undesirable situation. And the very places needing such in-service training programs most are probably the ones least willing and able to provide it.

Inadequate Opportunities for Obtaining Training

It is felt there are too few opportunities in Ontario for obtaining the following levels or types of nursing education.

Basic training at R.N.A. and diploma and degree R.N. levels. Depending on how great one feels the future need will be for R.N.A.'s and diploma R.N.'s, one will conclude there is a mild or great shortage of capacity in the R.N.A. training centre and diploma school systems due to a relatively slow rate of expansion in new schools and enlarged existing schools. The generally agreed upon shortage of teachers, administrators and public health nurses prepared by means of baccalaureate degree programs leads to the conclusion that the universities cannot at present produce the needed numbers.

Teacher, nursing service administration and public health nurse training at other than baccalaureate degree levels. If one feels that there is value in a form of training in the above specialties which is *less than* that obtained in regular Bachelor's degree programs, one will be dismayed at the rapid disappearance of one-year certificate courses at the university nursing schools and the absence of any other institution or organization prepared to provide equivalent training.

Clinical specialization. If one agrees that the future of nursing lies in more nurses being able to perform increasingly complex care and cure duties requiring special skill and knowledge, one will be struck by the almost total absence of any form of systematic, province-wide means for providing training in clinical specialties and, in fact, the failure to even agree upon the definition of clinical specialties in nursing.

Postgraduate training in all specialties at M.Sc. and Ph.D. levels. Everyone agrees that opportunities for all kinds of graduate study in nursing are pathetically inadequate in the light of even the most conservative estimate of future needs.

Orderly and nurse's aide training. As long as personnel at these levels may be required to perform anything but the most simple care activities on patients, and as long as social custom inhibits trained female nurses from performing certain procedures on male patients, there is need for such personnel to receive training at or near the R.N.A. level. Too many aides and particularly orderlies are not properly trained at present.

Factors Discouraging the Supply of Students

Financial support. Financial assistance is too small or too short-term for R.N.'s returning for a B.Sc. degree, or for R.N.'s progressing towards Master's or Ph.D. degrees. There is inadequate financial incentive for retired nurses to take the refresher courses necessary for them to return to practice.

Recruiting programs. Campaigns to recruit applicants for R.N. diploma schools tend to be on a small scale and of poor quality. No effort is made to attract applicants *other* than young high school graduate women.

Uncoordinated application processing procedures and variable admission standards (R.N. diploma level). These may result in a wastage of applicants potentially acceptable to one school or another and may be sufficiently confusing to discourage others from even applying in the first place.

Increasing difficulty for R.N. diploma nurses wishing to obtain baccalaureate degree. The switch from two years to three as the period of study necessary for a diploma graduate R.N. to obtain her B.Sc. seems to have at least temporarily dissuaded these people from returning to university full time. There are no other bases than full-time attendance on which they can work towards their degrees.

Declining attractiveness of nursing as an occupation today for young women with satisfactory academic preparation. This is alleged by some to be the case, but there are few longitudinal empirical studies to support the argument and none showing that the supply of potential recruits to nursing actually has been fully tapped.

Decision-Making in Nursing Education

The predominant pattern of the decision-making process in nursing education in Ontario today is one of confused and overlapping authority and responsibility in a highly decentralized system. Power over one or more of the problem areas discussed above lies with individual schools, individual hospitals, the College of Nurses, the Ontario Hospital Services Commission, and the Department of Health. Significant influence is brought to bear on each decision-maker by representatives of each of the other centres of authority and on all of them by outside interest groups such as the Ontario Hospital Association, the Registered Nurses' Association of Ontario, and, to a lesser extent, the Ontario Medical Association and Ontario Association of Registered Nursing Assistants.

Role of the Nursing School, Faculty or Training Centre

That the individual schools of nursing still retain considerable influence over their own destinies in the face of extensive formal and informal controls exerted over them by a variety of larger entities is evidenced by the striking diversity from one school to another as revealed in Chapters 6, 7 and 8.

Individual Diploma Schools

Within some broad limits and constraints mentioned below, each diploma school of nursing can decide whether or not to exist; whether or not to merge with other schools; how big it will be; what physical and other facilities it will provide; what standards of participation to impose; and the length, curriculum and pedagogy of the program.

Legally imposed and uncontrollable limits to decision power. The above decisions cannot be made arbitrarily. They must be made within the constraints of governmental laws and regulations, and take account of uncontrollable market forces.

The Nurses' Act states that a diploma school may not operate without the approval of the College of Nurses, and the Regulations of the Act list the criteria the College must use in deciding whether or not to grant approval. Thus the Regulations specify minimum admission standards, faculty qualifications, program length, general curriculum content, and the amount and type of instruction or experience within each subject.

The Ontario Hospital Services Commission, as the source of almost all funds for diploma schools, has approval power over how much each school may spend and what it may spend it on.

Hospitals have authority to grant or withhold permission for a school to use its clinical facilities for educational purposes.

The availability of staff and students with given types of academic preparation and the strength of demand for graduates exert a kind of "labour-market" influence on the school's decisions regarding admission standards, performance standards and minimum faculty qualifications (above the minima laid down by the Nurses' Act).

The internal decision process. The process by which decisions are reached within diploma schools is quite variable. It depends partly on the formal structure of the school and partly on the extent to which the school practises decentralized and participative management.

As of the fall of 1967, there were fifty-five diploma schools (actually operating or with College approval to operate) in which ultimate control lay in the hands of the board of trustees of a single hospital. There were twenty-one with entirely independent boards of directors. Three were controlled by the Department of Health [those in Ontario (Mental) Hospitals] and one by a community college. Of those controlled by hospitals, fourteen had separate school management committees to whom the director of the school reported; in the remainder the director was responsible directly to the hospital board. In the case of schools with "independent"

boards, it is not clear exactly how independent these boards really are. Most of the schools in this group are regional schools, but for budgeting purposes the OHSC assigns them to an individual hospital. In some cases, the board of the hospital to which the regional school is assigned insists upon reviewing and passing on the school's budget before it goes forward to the OHSC. So far, this has been a strictly *pro forma* procedure with not even a question being raised by any hospital board; but it appears that, legally, the hospital board *could* still interfere with the school budget. This situation seems to prevail also for two of the supposedly completely independent two-year schools in Toronto — Nightingale and Quo Vadis.

The operating head of diploma nursing schools is the director. In eighteen of the fifty-five hospital-controlled schools, the official director is *also* head of the nursing service department for the hospital. In most of these cases the actual work of the director is delegated to an assistant director (nursing education). This form of management structure is rapidly fading out in favour of a full-time director, independent of the nursing service department.

Depending on the size of the school, the director may have one or more assistant directors. Aside from these, the structure within each school is determined largely by the director and depends to a great extent on how much of her authority she wishes to delegate to her staff. At the one extreme are those schools where almost all major decisions on curriculum, admission standards, staffing, expansion, and so on are made in faculty committees and based on studies and recommendations brought forward by subcommittees made up almost entirely of faculty members. Such a procedure is remarkably ponderous and has resulted in one school taking about three years to switch from a "two plus one" to a two-year program. At the other extreme are schools where the director retains full decision authority. She may consult some staff formally or informally, and she may use committees to generate data and recommendations; but she decides when to take action and what to do. This procedure seems to have been used at another school, which made the switch from "two plus one" to two-year in a single year. Between these extremes are schools with one or two standing committees on "curriculum" and/or "admissions" with varying systems for selecting membership (ranging from seniority to strict rotation) and varying amounts of authority (ranging from *de facto* decision power to simply making "recommendations" to the director).

In general, among the schools we visited in 1967, the predominant decision-making process within schools was broadly decentralized with regard to curriculum, while decisions on budget and staffing were more strongly controlled by the director. Like any other organization with overall goals which are occasionally conflicting, impossible to define in operational terms, and whose attainment is difficult to measure unambiguously, our impression was that most schools were

characterized as possessing a few cliques and factions representing opposing viewpoints on significant issues. At best, their skirmishes tend to slow down the decision time; and at worst, they substantially harm the quality of education in the school.

The relationship between the school and other organizations in the decision process. It has long been the contention of leading nurse educators that the quality of nursing education has been seriously affected by the service demands of the hospitals in which the students trained. The implication is that nursing school directors either willingly put service needs ahead of educational needs or were pressured into doing so by their superiors in the hospital.

There is little doubt that this *was* in fact the case; but it is a tribute to the influence of nursing leaders that it no longer seems to be so, even among schools still officially controlled by hospitals. Practically all the sure signs of hospital domination are now gone: "block" classes, uncoordinated teaching and practice, service-supervised practice, long work shifts, and many night and holiday shifts for students. All that remains of the struggle are the controversies over two-year versus "two plus one" length and the locus of province-wide policy on nursing education — both of which are raging far over the heads of the individual schools and hospitals.

While we could find no schools among those visited in which there were complaints of undue domination or even subtle pressure from hospital officials at any level, this is not to say there are none in the province; nor does this mean that service demands might not be made again sometime in the future. As long as schools are officially controlled by hospitals, they are potentially susceptible to influence by the hospitals.

At present, however, the locus of official control is being used as an official bogey man by both nursing leaders and hospital association officials. The former, who are sometimes dismayed at how slow some schools are in upgrading their standards and modernizing their curriculum and teaching methods, find it easy to blame the "antiquated" system of hospital-based control of schools. The latter, who are usually in a livid state over how slowly nursing schools are expanding or how long new ones take to get operational, lament the passing of close hospital control. In fact, the source of both problems tends to be within the schools themselves and in the extraordinary difficulties in planning and executing large-scale changes with an overworked, inexperienced or stagnant staff used to operating by a system of committees.

Aside from the influences on the individual schools from individual hospitals, there are the more significant influences from the College of Nurses, the Ontario Hospital Services Commission, and the Minister of Health and his advisors in the Department of Health.

On the one hand, the school feels pressure from the OHSC and Department of Health to make its contribution to the goal of 5,000 graduates by 1971. It is fully aware of the "master plan" which slates all but a few schools to either merge into a regional school or enlarge themselves. Communications from the Minister on down convey the need for quick change in the area of quantity.

On the other hand, through its program of trying to improve quality by moving existing schools away from service obligations to hospitals and changing schools to a two-year curriculum (with or without the "plus one" year), the College of Nurses is exerting pressure in that direction with its publication "Guide for the Establishment of Regional Schools of Nursing and Change of Existing Programmes" and with its insistence on reviewing progress and granting approval at three separate stages of development.

From both sources the pressure on the school is in the form of objectives, standards and policies to which the school should adhere in making changes. None of the three external organizations has the staff to send to the school for long periods of time to provide extensive advice and guidance. On the other hand, none of them can legally *force* the changes on the school either. As a result, each school does what it can in the context of its own resources and individual desire to expand, merge or upgrade itself. Some succeed magnificently on all fronts; others try and falter; and still others decide not even to make the effort. Meanwhile, above their heads, the larger organizations engage in mutual recrimination and charge each other with complicity in trying to frustrate each other's objectives for the schools. This higher level story will be told later.

Individual University Programs

Outside constraints and the internal process. The university-based schools of nursing have as much autonomy in their decision-making as, or more autonomy than, the diploma schools. They, too, must work within the framework of regulations set down by the Nurses' Act; but almost by definition, they far surpass these minimum criteria in all respects. They have no legal ties with hospitals and are not financed through the OHSC or Department of Health but through their university.

In another sense, however, they are more severely constrained than the diploma schools. They wish fervently to expand and increase their number of graduates of all types and at all levels. They also strongly want to be able to carry out much needed research in nursing. Their problem is the extreme shortage of qualified faculty. Because of the limitation of this crucial resource, the university schools have been forced to assign priorities to the utilization of their existing faculty. For most schools, the first priority has been to upgrade and expand the basic baccalaureate program. Typically, the emphasis has been first on the "quality" goal represented by changes from five-year non-integrated programs to the four-year

integrated type. This entails an immense amount of time and work since it means acquiring the staff, curriculum and clinical facilities for teaching basic nursing skills heretofore taught in the three-year off-campus phase of the five-year program.

Next has come the dropping of most one-year certificate programs so as to free faculty to participate in an enlarged undergraduate program.

The lengthening of the baccalaureate program for diploma school R.N.'s is primarily dictated by pedagogical rather than supply considerations, although faculty resource allocation also could be a factor in that it may mean fewer special courses need be given for this group of students.

Graduate programs and research have been reluctantly forced into a secondary role due to both the limited number of faculty and consequent heavy teaching loads in the undergraduate programs, and the even fewer faculty with special competence and interest in research.

It was not our impression that financial considerations per se were a major problem at present in most university schools. If schools could find the qualified staff, the university would make the money available to pay for them. What could be a problem for the schools is convincing university officials to pay "overscale" or authorize special employment conditions for prospective faculty in order to lure them from other universities. Perhaps when the new university medical and health science centres planned for several Ontario universities (for example, Toronto, McMaster and Western) are completed, the nursing schools attached to them will be more attractive to new faculty.

Interestingly, it appears as though the extreme autonomy of the nursing school faculties has begun to bother even them. In early 1967 a movement began to create an Association of Ontario University Schools of Nursing as a means of trying to coordinate the endeavours of the eight schools. Though the Association appears to be genuinely under way, it is not clear what influence it will have on the policies of the respective schools. Certainly some coordination is necessary if optimum use of resources is to be obtained in all eight universities for the greater good of the Ontario nursing profession as a whole.

Outside influences on university nursing schools. While it is clear that non-university-based organizations and individuals have little influence on the decision process in the university degree schools, it is worth noting at this point the extreme influence on them of ideas, values and programs developed in or promulgated by the leading university schools in the United States. That such an influence exists is understandable when one realizes that the majority of senior faculty in the established Ontario schools have received their training in these same United States schools.

It was the leading United States universities (especially, though not solely, Columbia University Teachers' College) which spearheaded the whole drive towards greater independence for nursing. This general aim has been manifested in the advocacy of the following: separation of diploma schools from hospital control; elimination of service obligations for students (thereby permitting reduction of program length by a year); emphasis on the "uniqueness" of nursing practice and its difference from the medical practice of physicians; and emphasis on the specialties of public health, administration and teaching, all of which increase either the power or autonomy of nurses by removing them from the role of "doctors' handmaidens". The United States universities have been the home also of the *belief* in a formal distinction between professional nurses (those with degrees) and nurse technicians (diploma graduates), along with the belief that a degree should be the minimum qualification for all but general duty nursing positions or their equivalent.

While many of the above beliefs and values could be said to be motivated solely by a desire to enhance the status of the nursing profession, there is little doubt that they have led to a significant improvement in the quality of professional nursing care. Whatever the motivation underlying them, however, and in spite of their beneficial effects, they also seemed to have had some dysfunctional effects, as recently pointed out by Davis, et al.:

1. The curriculum of many collegiate schools emphasizes preparing "well-rounded nurse generalists" as against "highly skilled clinical specialists," a policy which further dulls the hospital's appreciation of meaningful distinctions between baccalaureate and diploma graduates.
2. Closely related is the preoccupation of collegiate nursing education with the elusive mystique of "professional leadership" per se, and a concomitant failure to attend to the functional occupational bases upon which leadership can rest and sustain itself.
3. There is also the sometimes self-congratulatory predilection of collegiate nursing faculty to attribute nearly all of the deficiencies and abominations of contemporary hospital nursing to the "backwardness," "rigidity," and "task compulsiveness" ostensibly instilled by hospital schools in the diploma R.N.'s who populate the floors of American hospitals. The invidious appeal of the partial truth contained in this characterization, unfortunately, obscures for faculty, and secondarily for students, the important role played by purely organizational and structural constraints in the poor quality of much of the nursing care dispensed in hospitals.
4. Next, there are the, by no means unrelated, thought tendencies stemming from the strong infusion of psychotherapeutic concepts into collegiate nursing education over the past generation, namely, the habit of explaining conflict and animosity between, for example, patients and staff in terms of the attributes of individual personalities, or, sometimes, more abstractly as by-products of "poor communications" or a "bad set of interpersonal relations." That divergence of sentiment can be structurally induced and group vested is barely accommodated in this, alternately, overly optimistic and needlessly resigned view of human affairs.

5. Last, we have the historically understandable, yet increasingly anachronistic, reluctance of collegiate schools to assume a more active and direct part in the actual planning and execution of hospital nursing services, especially since these may offer opportunities to demonstrate and experiment with newer, more humane, and more comprehensive concepts of nursing care.¹

R.N.A. Training Centres

The structure and process of decision-making for R.N.A. education is much the same as that for R.N. diploma education. There are one or two differences, however. While individual diploma schools can choose to run their programs over a longer period than the two-year minimum laid down in the Nurses' Act, apparently R.N.A. centres cannot.

R.N.A. training centres, based in the high school system, apparently manage to remain fairly autonomous from the main centre of secondary school curriculum formation. They lean heavily on the knowledge and experience of people connected with Department of Health programs. Their main difficulty is in arranging clinical experiences in the hospitals; they seem to come last on the list of priorities below hospital-based R.N.A. and R.N. students and non-hospital-based R.N. diploma and degree students.

Department of Health R.N.A. training centres, of course, have far less ability than the R.N. diploma schools to resist pressures from the Minister and his advisors to expand rapidly and extensively. However, with slightly larger resources, a solid core of experienced personnel, and no concomitant pressure to upgrade quality, the Department of Health training centres are also more willing and able to respond to the call for expansion.

Role of the Employing Agency in Nursing Education Decisions

As indicated earlier, the individual hospital no longer appears to have much formal or informal influence on the nature of nursing education, even though many hospitals are still the legal operators of diploma schools. Given this general situation, they remain very important in several specific areas that ultimately affect at least the quantity of places available for diploma students.

When it comes to the creation of new diploma schools or the creation of regional schools through merging existing schools and pooling the clinical facilities of several hospitals, hospital boards of trustees and key officials are all-important. They tend to be the ones who have to take the initiative in forming the Steering Committee which must plan and gain acceptance for the creation of the new entity. Long-standing rivalry and competition between hospitals in a given locality have

¹Fred Davis, Virginia L. Oleson and E. W. Whittaker, "Problems and Issues in Collegiate Nursing Education" in Fred Davis, *op. cit.*

led to delays or outright refusals to cooperate in forming regional schools. Some Catholic hospitals do not want to cooperate with public hospitals in the same town; Fort William will not join with Port Arthur, and so on.

The main basis of the hospital's control over this initial phase in diploma school development is its complete control over its clinical facilities. Without access to adequate hospital facilities no school can function.

A secondary basis of the hospital's influence on the creation or merger of schools is its control of its land. It seems to be the implicit desire of a new diploma school to locate itself physically adjacent to one of the hospitals which it will utilize for clinical experience. Some hospitals squabble within their own organization over how much land to make available and on what terms, while in a few other cases two or more hospitals cannot agree on which one of them will be the site of the new school. In all such cases, the hospitals apparently retain sufficient autonomy from the OHSC and other government bodies that the most these higher level bodies can do is urge them by means of letters and visits to resolve their conflicts. Perhaps more effective pressure will be brought to bear as the whole concept of the regionalization of health services currently sponsored by the Minister of Health becomes more fully developed and implemented over the next few years.

Quite aside from their role in creating diploma schools, there is the part the hospitals and other agencies play in the allocation of clinical facilities for all existing nursing education at all levels: R.N.A., diploma and degree. The present process is a highly individualized one involving the director of the school and the director of nursing service, and perhaps the chief executive of the agency. Where there is no competition for the agency's facilities, there is usually no problem in arriving at the agreement to admit students to take advantage of whatever clinical experiences are available. As we have seen, however, in certain parts of the province there *is* a situation of several schools applying for access to the same clinical facilities. When such is the case, the decision to approve admission by the hospital becomes much more complicated. Their first tendency is naturally to accommodate the students in their "own" programs if they have them. After that, the decision is variously influenced by past practice, by how good a selling job each school can do in presenting its own case, and by the position of the applicant school director in a complex "old-girl" network of interpersonal relationships.

An OHSC-College of Nurses committee has recently been formed for the purpose of taking an inventory of the number and type of existing clinical facilities, and how they are presently used. This will doubtless lead in time to a more controlled and rational system of allocation than presently used.

As mentioned previously, the traditional basis of a hospital's influence on the educational process for nurses has been in the area of its demands for service

from students in return for sponsoring the school, providing "free" training, and making the facilities of the hospital available. It is now fairly well agreed by both hospital administrators and nursing educators alike that the costs to the hospital of operating a nursing school are greater than the monetary value of the student's nursing services. Furthermore, with the advent of government financing, the hospital as such need no longer raise the money to pay for its nursing school. In spite of this, many hospitals are still loathe to see the emergence of two-year programs of nursing education in which no service of any kind is provided by students. The reason for their objection is primarily that there are problems inherent in having to replace the students' services with those of qualified graduate nurses. To the individual hospital, the cost of additional staff is not so much the issue (though it may well be seen as a problem at the government level) as the difficulty of finding, training and keeping such staff.

While it is not clear that there is a serious shortage of graduate nurses at present (as was shown in Chapter 3), neither is there a surplus, and the competition for such staff is great. Furthermore, once obtained, graduate staff are in many ways not as reliable as student staff, since they do not usually stay for long and the recruiting process is never-ending. In the case of students, there is an automatic supply every year, they cannot quit at awkward times, they will not form or join a union, and they have even had two years to get used to the hospital's unique way of doing things (while new graduate staff must be oriented). All in all, one can well appreciate the reluctance of hospital administrators to bid farewell to the practice of nursing student service obligations (even though they do not use the same arguments as those expressed above when voicing their opposition).

The point is that hospital officials do *not* seem to be pressing their case to the directors of the nursing schools. Rather it would appear that their disappointment over the lost student services is expressed within the context of the Ontario Hospital Association and possibly upward to key officials in the OHSC and Department of Health. We have no direct evidence of this, but it is clear that the antipathy towards rapid introduction of two-year nurses' training found within the OHA, OHSC and Department of Health is not based solely on the financial costs of replacing student workers with graduate staff.

The final area of nursing education in which hospitals have a major say is, of course, that of in-service education. The process by which decisions are reached on the amount and type of in-service education to offer is highly complex and variable from one hospital to another. It depends first on the background, interests and available time of the person who fills the position of in-service education director (if there is such a person in the first place). Without a well-qualified person, little or nothing gets done. Given that there *is* such a person available and that she is full of useful ideas for needed in-service programs, there are numerous difficulties placed in her way before they can be implemented.

Programs for nurses only must be cleared with the director of nursing, then subordinate supervisory staff must accept the need for the program, be willing to release staff, and be able to "cover" for staff attending the program.

Budget considerations prohibit the hiring of enough qualified trainers to help prepare and give additional programs.

Getting supervisory staff involved in preparing or presenting programs is a difficult task even *with* the enthusiastic support of the director of nursing.

Development of programs for administrative and supervisory staff themselves are often the most badly needed of all types of in-service education, but they are also the most difficult to gain acceptance for.

There is rarely a workable system for planning or giving *interdepartmental* programs of any kind; thus, few are given. Even if a formal system were set up to facilitate hospital-wide planning for in-service training, there would be problems in making it work due to long-standing interdepartmental conflicts and rivalries which inhibit representatives from the various specialized units in the hospital from taking an organization-wide perspective.

Role of Province-Wide Government, Professional and Employer Organizations

Once one leaves the level of decision-making in the individual schools and agencies and moves to the area of policy formulation on a province-wide basis, the picture becomes immensely more complex. At this higher level, it is no longer possible to discuss the role of specific bodies or organizations one at a time. As will be seen, responsibility and authority may *seem* to be clear-cut at first; but in actual fact, most major decisions are arrived at by a process of joint consultation, negotiation and the informal use of pressure and counterpressure within and between the main official bodies: the College of Nurses, the OHSC, and the upper echelon of the Department of Health as well as non-governmental groups like the OHA and RNAO.

The nature and extent of this interorganizational decision-making process is best illustrated by a description of the development of policy in nursing education between 1965 and 1967. First, however, we will identify briefly the main organizations in the story and mention a few areas in which they do have maximum authority with minimum influence from outside organizations or groups.

The Ontario College of Nurses began operation in 1963 for the purpose of administering the Nurses' Act, which controls admission to practice as an R.N. or R.N.A. and standards of basic R.N. and R.N.A. education in the province. The College is governed by a twenty-one member Council, eleven of whom are elected on a regional and R.N. population basis by all registered nurses. The RNAO appoints four members, while R.N.A. interests on the Council are represented solely by *one* member who is appointed by the Ontario Association of Registered Nursing Assistants. The Council has most of its agenda created for it

by its permanent staff, an Executive Committee, a Discipline Committee and an Educational Advisory Committee. This latter group of ten contains appointed representatives of the RNAO, Department of Education, undergraduate medical teaching, the OHA, the OHSC and university schools of nursing. There are no official representatives of R.N.A. education nor R.N. diploma schools of nursing.

Where the College has its greatest autonomy in the area of education is in setting the basic curriculum for R.N. and R.N.A. education. Of course, *within* the Council and its sub-bodies there are represented all shades of opinion on this matter; but in the end, discussion, consensus, or — if necessary — voting decides things with relatively little interference from outside organizations or groups.

The Ontario Hospital Services Commission contains two major departments — Finance, and "Hospitals" — each headed by a Commissioner. Finance, in its Hospital Budgets section, must review and approve the budgets for most diploma nursing schools. It does this with the advice and assistance of the Senior Consultant of Nursing Services (a subsection of the Hospital Operating Standards section in the "Hospitals" department) and the head of the Hospital Standards section. The Finance Department also reviews capital expenditure requests from nursing schools sharing this activity with the Hospital Planning section as well as the others already mentioned. The Finance Department's approval of all expenditures must, in turn, be approved by the Executive Committee of the Commission before it is final.

Its control of school budgets gives the OHSC considerable indirect influence over many matters, but it most directly and autonomously has the say in setting the upper limits on the salaries and number of teachers, and the size and nature of physical facilities, and other capital expenditures for the diploma schools and R.N.A. programs. For example, if a school wishes to have a swimming pool, a large lounge or an auditorium in its nurses' residence, the OHSC has approval power. Conversely, the Commission may put strong pressure on a school to provide a residence for its students when the school originally had not intended to do so.

The same control of the purse strings for expenditure in provincial hospitals provides the Commission with the power to encourage in-service training through approving separate budgets for this activity. (It does *not* do so at present and hence, in effect, *discourages* it.)

The Department of Health involvement in nursing education is found primarily at the level of the Minister of Health and his chief advisors within the Department — the Deputy-Minister and the newly created Ontario Council of Health. Most of its activities involve the participation of extra-departmental bodies (these will be discussed below); however, it also has autonomous control in the areas of bursaries for nursing education and the operation of the Department-sponsored R.N.A. training centres and those nursing schools based in government-owned mental hospitals. All provincial bursaries for nursing are administered by the Chief

Nursing Consultant within the Public Health Division of the Department, but the total amount available is set at the top level of the Department. The Chief Nursing Consultant is not involved in this decision. The operation of the departmentally controlled schools and training centres appears to be thoroughly decentralized with the exception of the question of size, where again top echelon policy dictates the degree and rate of expansion to be embarked upon.

The Registered Nurses' Association of Ontario and the Ontario Hospital Association are the two main non-governmental bodies with strong interest in nursing education policy in the province. They have no official power of decision but are consulted by and represented on most policy-making bodies. Quite understandably, the R.N.A.O. has close ties with the College of Nurses. It used to perform many of the functions of the College and a number of nursing leaders hold, or have held, executive positions in both organizations. Similarly, the OHA has a history of close association with the OHSC. It, too, once performed functions now undertaken by the OHSC. Several of the past or present top executives of the OHSC have been officers of the OHA, and it is not uncommon for OHSC administrators to become administrators of individual hospitals, and thus members of the OHA.

Development of Provincial Policy on Nursing Education Between 1965 and 1967²

The 1965 Plans

In Chapter 4 on "Nursing Supply and Demand", the story of governmental policy was taken up to the point where two major committees appointed to investigate "the nursing shortage" concluded that there was one, and that the primary solution to it lay in doubling the number of graduates from R.N. and R.N.A. nursing schools. The reasons for the popularity of this "educational solution" among the majority of representatives on the investigating committee advising the Minister also were discussed in Chapter 4.³

²The reader should again be reminded that the following description is based on information obtained from interviews with a number of the officials actually involved in the evolution of the policy on nursing education. Most of these informants requested that their identity not be revealed. The details of what happened as told by one informant were checked against those presented by others. We found high agreement on the information conveyed by the various informants.

³By contrast it is interesting to note the conclusion of the recently published *Report of the National Advisory Commission on Health Manpower*, Vol. 1, U.S. Government Printing Office, Washington, November 1967, pp. 22-23:

. . . the present and projected shortages of nurses do not reflect a shortage of training facilities or of nursing graduates. More places are available in nursing schools than there are candidates to fill them. . . . Given the large number of non-practising nurses, increasing the output of new nurses is not the best means of attacking the nurse "shortage". The most important actions are those which will make nursing a more attractive profession and thus entice trained nurses back to duty as well as lower the attrition rates of students and new graduates.

The upshot of the Ad Hoc Committee on Nursing was to have the OHSC conduct a rapid survey of the fifty-six hospital schools of nursing then existing. Each school was visited by a team consisting of a nurse consultant, a consultant in hospital administration, and a physician. Their objective was to gather data on the existing physical, clinical and instructional resources so as to better be able to plan how to increase enrolments.

Following the OHSC survey, the Minister created a "Working Party on Nurse Education", which was charged with the responsibility of bringing forward detailed recommendations for the expansion and establishment of schools of nursing to meet the 5,000 graduates per year objective. The Working Party consisted of three people only: a representative of the OHSC, who acted as chairman (this representative was the head of the Hospital Operating Standards section of the Commission); a representative of the College of Nurses; and a representative of the Ontario Hospital Association.

The Working Party laboured long hours for four weeks and on March 29, 1965 produced its *Report*. This report presented a thorough analysis of the existing situation and offered a detailed plan for the development of regional schools and the expansion of existing schools on an area-by-area basis throughout the province over the next five years.

Somehow (we could not discover exactly how) in the deliberations of the Ad Hoc Committee on Nursing and/or the subsequent Working Party, the decision was made to accede partially to the demands of the nursing profession (and the recommendation of the federal Royal Commission on Health Services) that R.N. diploma nursing education be reduced from three years to two in length. The compromise recommendation was the "two plus one" system to last until about 1975, when it would be replaced by a straight two-year course. Apparently the main arguments offered by representatives of hospitals for not going directly to the two-year system were financial — the cost of replacing "free" student service with that of graduates. Nursing representatives reluctantly accepted the compromise on the understanding that it would be a temporary arrangement.

The detailed Plan of the Working Party involved the following steps in its implementation:

- 1) A series of conferences and meetings with chairmen of hospital boards, administrators, directors of nursing and directors of nursing schools in each of the regions of the province to acquaint them with the problem and urge that they accept the Plan; and to work quickly to start forming regional schools, to acquire new physical and clinical facilities, and to get the necessary additional staff — whatever the plan said was needed in order to implement the objective for their area.

- 2) The OHSC, the College of Nurses and the OHA would offer advice and assistance to each of the areas at their request to aid them in making the necessary changes in expanding, merging, and changing to a "two plus one" curriculum. The province guaranteed to pay all additional expenses incurred in carrying out the expansion.
- 3) The College would sponsor and conduct a series of "Institutes" to prepare 100 "teaching assistants" per year for three years to ease the shortage of teachers which would be created by increasing the number of schools and students. It would attempt also to centralize information on nursing student applicants to overcome wastage due to acceptable students being turned down by the school to which they applied and places in schools going vacant because of students being accepted and not appearing.
- 4) The university schools were to make every effort to double the number of degree graduates and hence the number of potential teachers for diploma programs.

Most of the above information on "the five-year plan" for nursing education was disseminated throughout the province by means of four "Nursing Education Conferences" in Ottawa, London and Toronto in June 1965, to which were invited all those in the region with any responsibility for any facet of nursing education. The conferences were addressed by the Minister of Health, the Commissioner of Hospitals for the OHSC, a representative of the College of Nurses, a representative of University Schools of Nursing, and the President of the Ontario Hospital Association. The papers presented at these conferences were subsequently published as a booklet by the Department of Health under the title, *Proposals for the Future Pattern of Nursing Education in Ontario*.

By the summer of 1965, the existence of the excellent detailed Plan and the success of the heavily attended conferences created a sense of high optimism and confidence among provincial and hospital officials that the "nursing shortage" was well on its way to solution. Having mapped the course for the future, they had a satisfied feeling of a big job, well done.

By early 1967, only a year and a half later, it was clear that very little was in fact being accomplished in implementing the Plan. Enrolments were supposed to increase immediately by about 500. They went up by 300 in 1965. They held steady in 1966 and went down by 100 in 1967. The regional schools were (and are) slow in getting started. Existing schools, on average, were not expanding greatly. University-based schools were temporarily, at least, turning out fewer numbers in total (due largely to cutting back certificate courses). The promised system for turning out 300 teaching assistants had never materialized. There was no progress in improving the application system. What happened?

Reasons for the Slow Implementation of the Plan

One problem that the Plan did not take into account in calculating the time necessary to implement it was difficulties that schools might encounter in switching to a "two plus one" type of curriculum if they were not already operating on that basis (and most were not). As the College of Nurses representative correctly pointed out at the conferences on the Plan, this change is not simply a compression of the existing curriculum from three years into two with the "plus one" left over for work. Rather it was symbolic of all the recent trends in nursing education. It meant presenting subjects in a different sequence, using very different pedagogical techniques. In sum it meant for many schools a considerable upheaval in the structure and content of the educational experience they offered.

The system for implementing the Plan was basically a decentralized one, in keeping with the general approach to hospital operation in the province. In each area, each school and hospital was totally responsible for planning and implementing the *detailed* procedure for expanding, merging or changing the curriculum. In most locales all this had to be undertaken in a context variously comprised of one or more of lethargic hospital boards; traditional local rivalries and conflicts; and overworked hospital administrators, nursing directors and nursing school directors, burdened by routine daily chores and crises and lacking the necessary training and background for the expansion and upgrading tasks.

At the level of the OHSC and the College of Nurses, both of whom were expected to provide pressure ("encouragement") plus concrete advice and assistance to the individual areas, there was also an immense shortage of staff with the qualifications and time to visit the areas. The best that could be managed were visits to, and correspondence with, the few areas with sufficient enthusiasm, energy and talent to ask the provincial organizations for assistance. Furthermore, the College in 1965 and early 1966 was involved simultaneously in "breaking in" a newly elected Council, and trying to complete an improved R.N. and R.N.A. registration system. On top of this, its one nursing school inspector resigned to return to university. One "consultant" in nursing education was employed by January 1966, but she could hardly service all the areas needing help. The OHSC possessed only four nursing consultants on its staff, all of whom had a full load of hospital nursing departments to visit and none of whom were experts in the area of education. Nor did it possess enough experts in nursing school facility and building design to visit the areas to advise on this aspect of the problem.

It was not until June 1966 that the College and the OHSC jointly published a small (twenty-six page) booklet titled, "Guide for the Establishment of Regional Schools of Nursing and Change of Existing Programmes". This guide was to be used as:

- 1) Informative and interpretive material by faculty and other groups interested in establishing a new school or changing an existing program.
- 2) An evaluation tool by schools and by the Council of the College of Nurses in assessing the adequacy of the program (p.v.).

At the time, it was accepted by all as a list of the steps to follow in making the changes recommended for each school and new schools by the Plan. No one seemed to worry whether the steps were official regulations of the College or OHSC, or true guidelines to which adherence was not *required*.

The proposed system set up by the College of Nurses for developing teaching assistants managed to launch four of the "Institutes" between August 1965 and January 1966. At each one, enrolment was progressively smaller, so that fewer than the planned total of 100 were turned out. They were dropped after the first year with OHSC consent. The reasons were twofold. First, the College did not really believe in the teaching assistant concept as the best means to ease the teacher shortage. Furthermore, it did not have enough qualified and interested staff to define the role of the teaching assistant in detail and help each school make optimum use of such people. Second, as a result, the individual schools were unsure of what to do, and they expressed this by not sending participants.

The project for centralizing information on applicants to nursing schools was launched by means of a questionnaire sent to all schools. Unfortunately the design of the questionnaire was not all it could have been — certain kinds of desired information were not solicited and other questions were ambiguously worded. As a result, the data obtained were not particularly useful.

The various universities experienced the resource shortages described earlier and some became embroiled in the difficult business of changing from five-year to four-year integrated programs, all of which led to cutting back on certificate courses and elongating the degree programs for diploma-trained R.N.'s.

Developments in 1967

By the end of 1966, the OHA was growing increasingly impatient with the slow progress in implementing the five-year Plan. At its 1966 fall conference, it chose to attack the College of Nurses publicly for "dragging its feet" in issuing "approvals" to nursing schools as they sought to expand, merge, and change curricula. The implication was that the College had no real interest in increasing the number of graduates but wished only to impose its preferred type of program on the schools — that is, an independently controlled, two-year curriculum; better qualified teachers; and so on.

Early in 1967 the OHA appealed to the Minister of Health to investigate the whole situation. He, in turn, passed the complaint to the newly created Ontario

Council on Health. The Executive Committee of this group met with representatives of the College and the OHA on at least five separate occasions between February and June. Each side prepared a brief outlining its position on nursing education. The Committee also launched a legal investigation into the right of the College to have a consultant on nursing education and its right to deny a school approval on any grounds other than failure to meet the explicit criteria on curriculum and faculty qualifications laid down in the Regulations to the Nurses' Act (that is, its right to use the June 1966 "Guide . . ." booklet to evaluate new schools and to change old schools).

The details of these meetings and investigations will not be covered here. Although we did not obtain full accounts of what went on in the meetings, there was apparently considerable debate among nursing officials, OHA representatives and committee members, some of it reasoned, some of it acrimonious. From what we can gather, the evidence collected by the Executive Committee consisted mainly of verbal reports from the OHA, College and OHSC representatives. By March, it was clear to members of the College that the OHA view of the situation was dominant. This was when the legal status of the College was investigated.

By May, the Chairman of the Council on Health (the Deputy Minister) had prepared and circulated to all parties a seventeen-point position paper based on the information gleaned from previous meetings and submissions from the OHA, the College and the OHSC. Among other things, it reaffirmed faith in the correctness of the "5,000 graduates" goal; emphasized the short-run priority of quantity over quality (schools which are "unlikely to meet standards in the future . . . will probably have to be retained until they can be replaced without adversely affecting our ability to graduate students"); recommended a halt to changing the "basic structure" of existing schools (from three years to "two plus one", and so on), unless such changes could be made "within the framework of the immediate provincial objective"; recommended a lower admission standard — grade 12 in the four-year stream; and told the College to confine its efforts largely to its statutory responsibilities (that is, no more "consulting"). It alluded also to the need for more research on supply and demand, better recruiting efforts, more attempts to obtain nursing staff from sources other than nursing schools, and the need to turn out more teachers — all points put forward by the College. However, its most explicit recommendations were directed at boosting enrolments fast. Finally, to ensure that progress be made, it was recommended that a group of "super-consultants" be created within the Department of Health to take over the implementation of the Plan — that is, to take this responsibility away from the OHSC and the College who had previously shared it.

The "Seventeen Points" paper was discussed at subsequent meetings of the Council on Health Executive Committee, with OHA and College of Nurses representatives present. Most of its points were accepted by the Committee, with the College voicing strenuous protest to the creation of the "super-consultants" group.

Nevertheless, on July 27 a letter went out from the Minister to all chairmen of boards of hospitals involved in nursing education, all chairmen of nursing school boards and all directors of schools. This tersely worded two-page document states that to implement the 5,000 graduate objective, "The Department of Health will be responsible for overall coordination and will have the full support of the Ontario Hospital Services Commission." It goes on, in effect, to tell all recipients to get things moving at their end as fast as possible.

College of Nurses (and R.N.A.O.) opposition to removing authority from the OHSC and College for implementing the Plan continued and eventually seems to have resulted in the abandonment of the super-consultants concept and creation of a Joint Liaison Committee on Nursing Education between the College and the OHSC. The Department of Health is represented on the committee. The working of this Liaison Committee is to be periodically scrutinized by the Council on Health. Meanwhile, a subcommittee on nursing education has been formed within the Committee on Education of Health Disciplines of the Council on Health, to bring forward recommendations for the long-term objectives of nursing education.

Summary

What the above story illustrates is not simply the classic battle found in all professional occupations of the forces of quantity against the forces of quality and upgrading. Such conflicts are inevitable and probably healthy when organized properly and when both sides have similar power. More subtly, it is the story of how this conflict can become intensified and unbalanced as the result of decentralized implementation of provincial policy with inadequate resources to guide and aid the many individual units responsible for turning plans into practice. The nurses have never had a strong voice in determining their own destiny at the level of provincial policy. The creation of the College in 1963 was their first significant step towards more equal power vis-à-vis the employers of nurses. They negotiated quality objectives into the Plan for increased numbers and then became the scapegoats when the implementation of the Plan faltered. They came within an inch of de facto loss of their control of nursing school standards, mainly because they, the OHSC, the OHA and the Council on Health were not willing to place the blame for the Plan's failure on the inevitable slowness of an implementation procedure requiring a very large, long-established, decentralized system of individual units to undertake major changes without a large amount of pressure and aid. That the OHA chose to lead the attack on the College instead of haranguing its member hospitals to get moving was unfair, but perhaps understandable in the light of the dependence of its executive officers on the support of the Association's member hospitals.

Opinion on Decision-Making in Nursing Education

The College of Nurses, the RNAO and the OHA are all dissatisfied with the present system of arriving at decisions concerning nursing education.

Spokesmen for the nursing profession have long and consistently advocated that nursing education be totally removed from the influence of nursing employers. They would like to see the ultimate authority for and financing of education in the hands of the Department of Education and the individual schools placed under the direction of completely independent boards of directors. They are somewhat vague regarding how precisely to fit nursing schools into the Department of Education structure, and the amount and kind of authority this central body should have compared to that vested in the individual schools.

The underlying reason for these beliefs by professional nursing spokesmen is their traditional struggle to escape domination by forces over which they feel they have too little control. They are convinced that the users of nursing services are just interested in having a large quantity of labour able to meet minimum quality standards only and available at lowest possible cost. When service forces dominate the educational system, the quality of education suffers; hence the only solution, so they believe, is to eliminate or drastically reduce their power and influence.

Representatives of the employers of nurses, in particular the Ontario Hospital Association, would like to take away much of the control of all professions in the area of health care from the various professional associations and place it under an independent governmental body. This body would undertake to adjust all government regulations concerning entrance requirements, education, licensure and discipline so as to obtain an optimal balance between standards of practice and the maintenance of adequate supplies of personnel. They feel that the nursing profession is as much in need of this kind of constraint of its authority as all the other professional groups.

The reason for this preferred solution is that the OHA is convinced that professions inherently tend to restrict supplies while enhancing their status through the "upgrading" of qualifications and educational standards. They are convinced also that the present machinery within the Department of Health for overseeing various Acts and Regulations governing the professions is inadequate.

While it is impossible to say how correct these views are with regard to other professions, it is clear that the nursing profession has *not* been successful in dominating the direction it would go in the area of education. As can be seen from the previous discussion, its voice in decision-making has not been strong, while the surveillance by the OHSC and the Department of Health of quantities educated has been far from lax, thanks partly to OHA prodding.

A detailed discussion of the above and other alternatives to the solution of the problems in nursing education is presented in the following concluding chapter to this report.

Chapter 11 Summary and Conclusions:

Alternative Approaches to Problems in Nursing

This chapter attempts to recapitulate the highlights of the preceding ten chapters by listing what we found to be the main problems affecting nursing in Ontario today; by discussing the reasons these problems exist; and by suggesting various approaches which might be taken to resolve them. The problems will be grouped under three main headings: those of nursing practice; supply and demand; and education. Only problems of some magnitude will be discussed. Relatively minor difficulties discussed in the body of the study are not included here.

It should be pointed out that by our concentration on problems in this summary, there is a danger that the reader might conclude that nothing is *right* in nursing. Such a conclusion would be highly erroneous. All parties concerned with nursing care in Ontario have been and are making immense contributions towards improving this care. There is no doubt that Ontario is second to none in North America in the amount and quality of nursing care available to its population. A majority of the problems identified are endemic to nursing wherever it is practised on the continent. Those unique to Ontario will be identified as such.

Problems of Nursing Practice

Problem 1

In general, the nursing profession is confused and moribund in charting the future course of nursing practice.

Details

In seeking, as all occupational groups do, to enhance its power and prestige, the nursing profession has adopted a negative rather than a positive strategy. These are some examples of this "negative" orientation to nursing practice:

- 1) Having historically been in positions of dependence and subservience to physicians and employers, nursing leaders have attempted to find the *raison d'être* of their profession by emphasizing duties and responsibilities which minimize this dependence. This has led to a concentration on administration and teaching as paths for upward mobility in the profession.

- 2) Leaders and spokesmen for registered nurses wish to do away with the classification of registered nursing assistants. Having been instrumental in *creating* the R.N.A. to overcome a nursing shortage and to serve as a vehicle for enhancing professional prestige (because "low status" tasks can be delegated to her), the R.N. now feels threatened by the R.N.A. because the latter is able to perform much of the R.N.'s job without the R.N.'s training. There are similar unresolved conflicts regarding the role of the university degree registered nurse as against the diploma school trained registered nurse.
- 3) In the area of public health there has similarly been an attempt to differentiate the role of the specially trained public health R.N. in a clear-cut, black-and-white fashion from that of the non-specially trained R.N.
- 4) In seeking to enhance the uniqueness of nursing, nurses have sought to define their role solely in terms of duties and responsibilities which are *not* shared with physicians or other paramedical personnel.

These negative or protectionist approaches to enhancing the power and prestige of nursing have resulted in the nurse looking away from the patient. There has been a striking failure to base claims for change within the profession on detailed, sophisticated studies of what type of patient and what type of health condition or illness requires what type of care.¹ If one views "patients", "illness" and "community health" in a diffuse, general fashion as nursing leaders have tended to do, there is no logical basis for distinguishing between R.N.'s with degrees, R.N.'s with diplomas, and R.N.A.'s; or between the roles of nurses, physicians and other personnel. Also, by trying to base their claims for prestige and power on vain attempts to define the "uniqueness" of nursing, nurses have chosen to ignore the interdependence of all occupational groups in the provision of health care.

How does a negative approach to professional development such as that described above differ from a positive one? In essence, the positive approach concentrates solely on the object for whom professional service is provided — the patient in this case. The patient and his health problems are analyzed, classified, and endlessly experimented upon so as to find the means for improving the quality and efficiency of service provided and identifying what services can best be performed by that profession as opposed to some other one. Where the services to be performed are interdependent with those performed by other groups, the

¹It must be noted that since the Second World War, one facet of nursing care *has* been empirically studied relatively extensively. This is the area of psychological or socio-emotional care. The psychological needs of the sick person and their effects on his recovery have been clearly established. It is less clear exactly how the nurse can diagnose and meet these needs, but there is a growing body of knowledge on this subject.

profession seeks to have an *equal* voice in deciding the exact nature of this interdependence (it does not try to force an artificial separation from the other groups). As a result of this concentrated research on the object of service, the profession might well define various subclassifications within it, but it will back up its claims with substantial amounts of research data. The basis for subclassification distinction will be *only* the patient's condition and the type of background and training needed to deal with it. The need to eliminate (or create) subclassifications will not be felt except insofar as research evidence suggests that patients would benefit if this were done. The profession would not be obsessed with defining professional boundaries other than in the light of empirical evidence that one occupational group could perform a given set of activities better or more efficiently than the other.

The most serious consequence of the failure of nursing to base its professional development on research into patient care is that it is unable to state clearly the future direction in which it wishes to move. At best, it is left with a mixture of vague, conflicting objectives: "back to the bedside"; "do away with R.N.A.'s"; "don't try to be a 'little doctor'"; "the nurse must be the socio-emotional care specialist"; "nursing service administrators, teachers, public health nurses and clinical specialists must hold university degrees".

Reasons for the Problem

If it is true that the nursing profession is today in a state which seems to be characterized by lack of purpose and by confusion over its future development; and if this condition is due to its failure to develop a positive orientation based on research into the health needs of patients and the community in general, the next question is why this situation has developed.

The primary cause lies in the history of nursing. There is no question that from the beginning nurses *have* been subservient to, and almost totally dependent upon, physicians and the agencies which have employed them (mainly hospitals). The medical profession has been the final arbiter of what nurses would or would not be permitted to do; and the employing agency has been the determinant of the income and conditions of work for nurses. Furthermore, this dependent role has been fully consistent with the role of women in society and hence has offered only the mildest frustration to the vast majority of nursing practitioners. Under these circumstances, in the past it was hardly possible for the nursing profession to establish large-scale groups or organizations to undertake sophisticated studies into the effects of various nursing procedures on different types of patients.

Another complicating factor is the very nature of such research. Unlike medicine, in which the effect of specific therapeutic and surgical treatments can be tested in a relatively clear-cut fashion, the procedures involved in nursing are

so numerous, so interrelated, and so much affected by other conditions in the environment that it is extremely difficult to test scientifically variations in a large number of them.

Inevitably in nursing there were those women who devoted their lives to advancing within the nursing profession and upgrading the status of the profession as a whole. This meant striving to break out of their position of servitude to physicians and employers. Since the route of scientific development was out of the question for them because of the reasons outlined above, their only approach was through one, or a combination of, the following: 1) trying to get jobs created which left the nurse as independent of supervision and control by doctors as possible (such as public health work); 2) trying to equalize power vis-à-vis physicians and employers by moving into the ranks of administration; 3) becoming teachers of nurses; 4) creating a system whereby advancement in the profession was based on the amount of formal educational preparation obtained (regardless of the lack of detailed scientific evidence on the effects of the content of educational programs).

By means of the above strategies, the leaders of the nursing profession *were* able to achieve striking gains in enhancing its status, autonomy and influence. There is no question, too, that in spite of the lack of large-scale, profession-sponsored and controlled research, intelligent and knowledgeable people attracted into the profession as a result of its higher status have done much to advance the quality of nursing care over the years.

In spite of all the progress, however, physicians are still the prime determinants of much of what the nurse may do; nurses still have but a weak voice in the operation of the employing organizations; and there are still few scientific criteria for determining how many classes of nurse there should be and how each should spend her time. The strategies of professional development which served well enough in the past are no longer effective in advancing the profession in the future.

Approaches to the Problem

There must be much more research on nursing practice. Nursing must involve itself with the advancement of the health sciences on all fronts.

In the universities this means more faculty, more money and more facilities for nursing practice research. It means more involvement of nursing faculty in certain branches of nursing service and medical research.

At the present time it is fair to say there is *not* a "research climate" in the university faculties of nursing. In particular, there is no research being done in the clinical area of nursing. This is due to too few staff, too much teaching, major changes in the structure of university nursing programs, and staff with inadequate research experience—as well as a lack of money and support from related disciplines and other interested groups.

One possible alternative to getting a significant body of research under way quickly would be to create an "Institute of Nursing Research" not unlike that created for education (the Ontario Institute for Studies in Education). Such a body would attempt to bring together all the nursing faculty and others with interest in doing studies of nursing problems. It would have affiliation with the best teaching hospitals in the province; and, although separately staffed and financed, it would be attached to a university and devote itself entirely to conducting nursing research with an emphasis on *clinical* research. It might also form the base for the development of a badly needed Ph.D. program in nursing.

With eight independent and widely separated universities, all geared to the primary task of educating baccalaureate degree nurses and all containing a very few faculty members with the interest in and ability to do research, a centralized research institute makes a great deal of sense. It makes sense on a national as well as a provincial level; therefore, federal support should be available for such a development.

In non-university nursing schools and hospitals as well, there is no reason why certain kinds of nursing practice research could not be carried on. If the diploma schools ever develop to the point of offering post-basic programs in clinical specialties, and if hospitals develop positions for clinical consultants, the teaching personnel and consultants would be aptly suited to performing a wide variety of relatively simple but very useful studies into the effectiveness of nursing procedures and systems.

The nursing profession must break away from the "artificial" basis of distinguishing between the various classes of nurse solely according to the length of formal nursing education. It must emphasize instead the special competences and contributions of each classification, thus minimizing the conflicts within the profession between the R.N.'s and R.N.A.'s, and degree and diploma trained R.N.'s.

Two important first steps towards attaining this goal would be for the Registered Nurses' Association of Ontario to merge with the Ontario Association of Registered Nursing Assistants; and for the Nurses' Act to be amended so as to include registered nursing assistants as members of the College of Nurses and to increase the representation of R.N.A.'s on the Council of the College.

The subclassifications of nursing personnel within a unified nursing profession should be defined on the basis of the type of patient and type of illness which their educational preparation qualifies them to nurse. That is, it should be more explicitly stated that the nature of the patient's nursing needs is the proper basis for distinguishing between classifications of nurse.

Although much research needs to be done to elaborate and corroborate this, it appears possible to distinguish in very general terms three levels of formal preparation:

- 1) Simple physical and psychological care for patients who are not seriously ill (the R.N.A. level).
- 2) More complex physical and psychological care and simple physician-assisting cure activities for patients who are moderately ill (the basic diploma R.N. level).
- 3) Complex physical and psychological care and relatively complex physician-assisting cure activities for critically ill patients; plus performance of complex, specialized functions such as administration, teaching and public health nursing (R.N. level with post-basic preparation).

This latter level assumes the development of well-defined, agreed upon and formally recognized "clinical specialties" within the profession. The lack of research on nursing practice to date has precluded the development of clinical specialties. The movement to formulate them has only just begun. As yet, there is no agreement as to what they should be, nor of what body of knowledge they should be comprised, nor where instruction in them should be obtained.

The study and clarification of specialties, including the traditional specialties of teaching, administration and public health, and their speedy recognition within the profession are without doubt the most important tasks facing the profession today. Until specialization based on function rather than formal education is officially introduced, the quality and quantity of nursing research will suffer, classification distinctions based solely on length of training will continue to cause destructive internal conflict within the profession, and the profession's power vis-à-vis its partners in the provision of health services — notably physicians and hospital officials — will be weak.

Unfortunately the move towards specialization in nursing must be nation-wide, if not continent-wide, if it is to be effective. The magnitude of the change makes it much more difficult to implement. The profession in Ontario can take the lead in urging change at the national level. Other steps are suggested below.

It is time for the nursing profession to stop fighting its domination by physicians and administration by trying to run away from them. It is no longer beneficial for the profession to try to define itself as independent when, in fact, its function is *interdependent* with those of the other members of the modern medical team. Instead it must concentrate on obtaining a position of *equality* on the team. This push for an equal voice in determining the role of nurses in health care must be followed aggressively on several fronts simultaneously. For example:

- 1) At the level of professional associations the Registered Nurses' Association of Ontario should try to increase its interaction with the Ontario Medical Association by means of joint committees on doctor-nurse relationships in provision of care; and through jointly

sponsored training and development programs for physicians and nurses on the role of each in hospitals and public health agencies.

- 2) The College of Nurses must seek to establish regular and continuing relationships with the College of Physicians and Surgeons concerning the nature of nursing practice. In particular, they should try to obtain a voice in the decision process on "special" — that is, medical — procedures which nurses will be permitted to perform. They should be able to initiate requests to have certain procedures delegated to certain classes of nurse, and they should be consulted when physicians initiate a change in this area.
- 3) The nature of nursing practice in hospitals is strongly affected by the design and facilities of the hospital and its policies on budget-setting, personnel administration, establishment of departmental responsibilities and individual job descriptions, and so on. Many of these policies are influenced by advice and assistance provided to hospitals by various sections of the Ontario Hospital Services Commission. At present, nursing does not appear to be strongly represented in the process within the Commission which creates the policy guidelines used by hospitals. Details on needed re-organization within the OHSC are discussed in the context of problem 2 below.
- 4) The RNAO should seek to re-establish its badly shattered rapport with the Ontario Hospital Association so as to maintain continuous dialogue on the role of nurses within the hospital and the role of nursing administration within the total administrative process in the hospital.
- 5) At the level of the individual employing agency, the profession must seek to achieve a stronger voice in the decision process. For example, nursing service directors should sit on hospital Medical Advisory Committees and the Executive Committee of the hospital. (This, too, is discussed more fully in connection with problem 2 below.)
- 6) All of the above efforts to obtain a more equal voice in the inter-dependent structure of decision-making on health services will come to naught unless the profession sends out as spokesmen its brightest, most articulate and knowledgeable spokesmen. In dealing with physicians, for example, only those nurses with the greatest amount of medical and nursing service knowledge should be chosen. Physicians are not impressed with vague declarations of the importance of psychological care or general claims that nurses have to do too much paperwork. They are impressed by an abundance of facts, figures and sophisticated discussion of clinical problems. The same holds true for administrators.

Not only must nursing spokesmen be "the best", they must also be prepared to be highly aggressive. If "quiet diplomacy" fails to improve their position vis-à-vis those "outside" authorities who have the greatest say in shaping the nature of nursing practice, they must be prepared to make their grievances public and otherwise bring pressure to bear in any legitimate way possible.

Finally, the nursing profession must learn to live with a diversity of goals. Part of the profession's all-consuming and basically destructive search for independence and autonomy vis-à-vis other health occupations has been the attempt to establish a *unique* function for nursing—a single concept embodying the essence of nursing. As discussed in the body of the report, the goals of nursing change according to the time, the place and the context in which the patient is placed. They are situationally determined. Thus the nurse's function variously comprises a mixture of being the only person to provide *continuity of care* for the patient; being an "assistant physician"; being a hygiene or socio-emotional care specialist; being an organizer and administrator of the patient's environment; and being a teacher of others. The point is not that the nurse must resign herself to being a "catch-all" category on the health care team, but that she must accept the fact that she must play a multi-faceted role and seek to discover which combination of functions she should perform in each distinct setting. Such knowledge will arise out of the dual processes of specialization and research suggested above.

Problem 2

There is considerable misuse of the province's nursing resources.

Quite aside from the direction of the *future* development of nursing practice, there is the more immediate and serious problem of the present-day use of available nursing resources. Whatever might be the gap between the ideal contribution which could be made by nurses and the contribution they are presently capable of making, it is certainly no worse than the gap between what they are now capable of doing and what they actually *are* doing.

Details

- 1) The most conservative indication of wasted nursing resources is the amount of time spent by the various classes and levels of nurse performing duties which do not involve direct nursing care and which are above or below the level of responsibility for which they were trained. This is revealed in recently summarized OHSC studies of nursing activity in 250 nursing units discussed in the body of this report. Anywhere from 11 per cent to 36 per cent of a nurse's time may be spent doing work above or below her level. If one assumes that most clerical, housekeeping, dietary and messenger activities required of nursing units could and should be performed by other than R.N.'s, nursing supervisors and R.N.A.'s,

it will be concluded that the 8 per cent of time that R.N.'s spend on such activities on average and the 18 per cent of time spent by the average nursing assistant is misused time.

- 2) The OHSC studies took the nursing unit's job description as the base from which to judge whether a nurse was performing above or below her level. It is quite possible that an additional proportion of her "official" duties so described could be performed by such personnel as ward clerks, "supply officers", messenger service or dietary personnel. The basis for this conclusion is the result of several studies on manpower utilization performed in the U.S. and on the combined opinion of a number of United States and Canadian nursing and hospital experts.
- 3) In the provision of direct patient care, there is considerable overlap in the activities performed by R.N.'s and R.N.A.'s, though there are no quantitative data indicating the amount of overlap in Ontario hospitals. The *erroneous* conclusion to be drawn from such a statement is that this overlap is undesirable and that R.N.'s and R.N.A.'s should do "different" work from each other. This is only partially true — there *are* certain procedures which R.N.A.'s are not trained to perform, and the quality of patient care is lowered if they are required to do so. (For that matter, there are also procedures which R.N.'s with only basic training are not capable of performing adequately.)

The true misuse of resources represented by "overlapping duties", however, is represented by situations in which large numbers of R.N.'s are used to nurse patients whose condition is not severe and is quite predictable (for example, post-partum obstetrical care, and certain chronic or convalescent patients). Such patients, who require less "psychological" care, little in the way of complex care and cure procedures, and little in the way of skilled and experienced observation, may well need fewer R.N.'s present. Conversely, more seriously ill patients may need fewer R.N.A.'s and more R.N.'s present to provide care.

- 4) There are still a number of hospitals in which the design, equipment and facilities for nursing units are far from optimal, requiring all levels of nursing personnel to waste time in getting to patients and providing for their needs.
- 5) The above examples of misused nursing resources refer mainly to the activities of individual R.N.'s and R.N.A.'s. Other personnel in the nursing unit also are inadequately used. Some hospitals have ward clerks to assist with paperwork and verbal communica-

tion into and out of the unit. It appears that such personnel are often of inferior quality and are poorly trained; as a result, the potential of the clerk's position is not utilized. In other situations, it is believed that the clerk is capable of doing more but the head nurse and staff nurses are unwilling to delegate their clerical duties to her.

The converse of this is head nurses and higher level supervisory staff who allow themselves to become involved in picayune, routine administrative work (which could well be done by secretarial or clerical staff), or who are unable to stop themselves from doing the same work as the staff they supervise. The result is inadequate time for training staff, coordinating them and acting as a resource person in helping staff members with their work problems. This situation is doubtless responsible for many of the difficulties in attempts at team nursing which we heard about in the course of our field visits.

Hospital orderlies are in a sort of limbo regarding their proper role in hospitals and other settings. In some places they are used primarily as messengers, housekeepers and weight lifters for nurses. In others, they perform procedures which are the responsibility of R.N.'s and R.N.A.'s. Some hospitals distinguish between "trained" and "untrained" orderlies, while others do not. Neither the R.N. nor R.N.A. professional associations will have anything to do with them.

- 6) As indicated previously, the area of public health nursing is in a state of flux. There is much debate, though little empirical research, on the amount and kind of duties and responsibilities which can adequately be undertaken by diploma-trained registered nurses and registered nursing assistants. The most it is possible to say is that the situation requires immediate, rapid and research-based investigation on how the resources of non-specially trained public health nurses may be better utilized.

Reasons for the Problem

Much of the responsibility for the misuse of nursing resources in hospitals belongs with hospital administration. The reallocation of non-nursing duties to house-keeping, dietary, messenger and clerical staff, and the creation of new positions such as ward clerks or supply officers must be decided upon at the top of the hospital hierarchy. The reason that investigations into the feasibility of such changes are not initiated or are improperly carried out may lie in one or a combination of the following difficulties:

- 1) The chief administrator of the hospital may be unwilling to undertake the effort required, or may be simply lacking in the knowledge or ability required to do so.
- 2) The medical authorities in the hospital may not appreciate the benefits to be gained from better nursing resource utilization, or may not have the time to participate in finding out.
- 3) Other departments which would have to accept responsibility for some of the non-nursing duties currently undertaken by nurses may be reluctant to do so and, as members of key committees, are able to vote down the investigation of possible changes.
- 4) Nursing service administrators themselves may resist change or, if desirous of change, have too weak a voice in the policy-making process in the hospital.

There is a lack of substantial empirical research on the establishment of optimum numbers and mixes of nursing staff for various types of situations.

The confusion in the nursing profession itself inhibits the introduction of change (see problem 1). For example, if it were possible to eliminate most of the nurse's clerical, dietary, housekeeping and messenger activities, it is not at all clear that a majority of R.N.'s would be willing and able to handle the increased amount of time they would have at the bedside. The failure to define and accept the role of the R.N.A. and to develop clinical nursing specialties leads to a lack of initiative in instigating and investigating more effective means for utilizing nursing resources.

The design of new hospitals, and renovation and re-equipping of existing ones do not always take adequate account of the effects of these actions on nursing. Similarly, many existing hospitals are in need of modernization to cut down on wasted movements and activities by nurses.

The system for grouping patients in hospitals is rarely suited to the amount and level of nursing care they require. This leads to a loss of predictability regarding staffing, with the result that there may be too few or too many staff, or too many or too few R.N.'s relative to R.N.A.'s and other aides.

In the area of public health, investigation and experimentation on the optimum use of R.N.A.'s and degree trained, one-year certificate trained and diploma trained R.N.'s is hampered by the Public Health Act, which requires nurses in government public health agencies to hold at least the one-year certificate. It is inhibited also by defensive attitudes on the part of those with specialized training who are unwilling to concede the possibility that diploma R.N.'s could do some of the things they do. Finally, there is no centralized body which feels responsible for undertaking the necessary studies and for making recommendations.

Approaches to the Problem

As an approach to the complex matter of getting hospitals to study means for improving nurse resource utilization and planning better designed and equipped facilities, it seems imperative to increase the expert advice and assistance available from the Ontario Hospital Services Commission.

At present, OHSC "consultants" have the dual functions of service and control vis-à-vis hospitals. They are supposed to help the hospital to improve its standards of care and, at the same time, make sure it adheres to various OHSC requirements and guidelines. These are very difficult functions to perform simultaneously. People with control functions are rarely viewed as friendly, warm, helpful advisors to whom one can bare all problems. Conversely, from the consultants' point of view, they never have the time or perfect freedom needed to work on a "client" hospital's problems in detail and at length. Finally, the staff of the present consulting services within the OHSC, set up to advise the various functional groups in hospitals, are almost as badly segmented and suspicious of one another as their counterparts in the hospitals they serve. What is needed in the OHSC, therefore, is

- 1) More consultants.
- 2) A splitting away of inspection and control from service and the setting up of a purely consulting department within the OHSC.
- 3) This consulting group should be made up of a number of specially constituted task groups or project groups comprising representatives of all areas of expertise with interest in a given problem. Their makeup would shift, depending on the problem. Allegiance of consultants to a particular functional or occupational group other than as a source of skill and knowledge should be discouraged. Thus a task group formed to improve the use of nursing resources within a hospital should have on it experts from the fields of nursing, administration, finance, hospital design, personnel, dietetics and housekeeping.

The alternative to an increased provision of pure consulting services by the OHSC is more direct centralized control of hospitals by the Commission. By this means, the duties and responsibilities of all types of R.N.'s, R.N.A.'s, orderlies, aides, housekeepers, clerks, dietary personnel, administrators, and so on would simply be laid down and enforced by the Commission for all hospitals.

A major program of large-scale research on optimum nursing resource utilization must be launched as soon as possible. Ideally, this would be an inter-occupational or interdisciplinary program, with subprograms on particular problems like the differentiation between general duty R.N.'s, R.N.A.'s and clinical

specialists in nursing. It should cover all types of employing institutions, not just hospitals. This research could best be carried out in a Nursing Research Institute such as that recommended on page 202.

Another alternative would be to have it coordinated by the newly constituted Research and Planning section of the Department of Health. This group could undertake to do certain projects or have particular projects contracted out to universities, major teaching hospitals, public health agencies, OHSC consulting teams, and so on.

What is important is to have an overall research design, coordination, and a very thorough system of information processing and distribution, so that those involved know what all research groups are doing.

The nursing profession must rapidly identify and develop a cadre of experienced and specially trained experts in administration, clinical specialties and public health to make available to province-wide research or consulting groups. It must also ensure that such persons have positions of real influence in any such group. For example, a nurse should probably chair any group set up to investigate improvements in nursing resource utilization in hospitals.

At the level of individual hospitals, nurses should be given more voice on key policy-formulating committees, including the medical advisory committee (see problem 1).

Hospitals should be encouraged in, and given special financial support for, conducting in-service training programs or participating in outside programs designed to upgrade the skill of administrators within hospitals and to improve interdepartmental coordination between the "middle-management" members of the organization.

An investigation should be launched immediately into devising standards of competence for orderlies, making their job descriptions more uniform; and perhaps arranging to have certain trained orderlies classified as registered nursing assistants.

Problem 3

There is lack of control over the quality of nursing care among small, private employers of nurses.

Details

In the case of personnel employed to do nursing in nursing homes, in private businesses and for individual citizens, there is no control over the qualifications of the person employed or the duties and responsibilities she may be required to undertake. There is little direct, systematic evidence that this situation has caused

suffering or has otherwise adversely affected the recovery of persons cared for in these settings. Anecdotal evidence provided to us by numerous individuals interviewed in the course of our study had to do with such situations as nursing home patients receiving inadequate care, industrial workers not being referred to physicians for serious problems, or private duty nurses being unable to recognize signs of danger in their patient's condition. At the very least, there seems no question that there is both actual and potential danger inherent in a state of affairs in which unqualified people may give nursing care to seriously ill patients.

Reasons for the Problem

There would be no problem if only registered nurses or registered nursing assistants gave nursing care for hire, or if non-registered nurses were adequately supervised at all times. Such an ideal situation cannot be attained at present, for several reasons:

- 1) There are not enough trained nurses to provide such extensive service to small private employers and, even if there were, many employers would be unable to afford the cost of such personnel.
- 2) The difficulty in specifying in any detail the calibre of qualifications needed to provide various kinds of nursing care makes it almost impossible to legislate on the matter. In the last analysis, it is probably true that much of the simple physical care provided to certain types of *mildly* ill patients does not require any formal educational preparation.
- 3) The machinery for checking on the quality of nursing care in such a large number of settings would be extremely complex, costly and cumbersome.

Approaches to the Problem

The Ontario College of Nurses and other associations of nurses would like to control the quality of nursing care by requiring the licensing of all those who nurse for hire and by restricting the use of the term "nurse" to those so licensed. At present, only the terms "registered nurse" and "registered nursing assistant" and their abbreviations are legally protected by the Nurses' Act. The introduction of this kind of change undoubtedly represents an ideal state of affairs to which it is desirable to aspire. It would certainly be a boon to the public to know that any time they hired a "nurse" or were treated by a "nurse", she had a minimum of R.N.A. training.

Unfortunately at the present time the type of licensing arrangement sought by the College does not seem feasible. While it would indeed be possible to restrict use of the word "nurse" to R.N.'s and R.N.A.'s, the fact of the matter is it is not yet possible to define in legal terms what activities do and do not represent the practice of nursing. Thus, there would be no guarantee that "non-nurses"

would not perform procedures or undertake responsibilities which were properly those of a nurse — any more so than there now is against non-registered nursing personnel doing such things.

Similarly, most of the work in nursing homes, and so on, now done by non-registered nurses, would still be done by them. There are not nearly enough trained nursing personnel to replace these people. All that would happen is that some euphemism would have to be coined to describe them.

In sum, to introduce licensing legislation which protects the use of the word “nurse” would not necessarily serve the public interest at this time. The basic problem of care being given by unqualified people would remain. In fact, such licensing laws might even have the effect of causing the public undue concern, in that they would be fearful of being given even simple physical care by someone who was not a nurse (when, in fact, it might be perfectly safe for such a person to give such care). What positive actions could be taken to improve public safety with regard to nursing?

A major objective for professional nursing groups should be to agree upon which activities and responsibilities should be undertaken only by registered nurses and registered nursing assistants (and perhaps even certain specialties within the R.N. group). If it can be clearly established that the public safety is threatened by unqualified people performing such duties, then they should push to have these restrictions to the practice of nursing incorporated into law.

In the meantime, associations of registered nursing personnel could mount large-scale and sophisticated publicity campaigns to inform the public just what the various classes of nurse are and are not qualified to do. These campaigns should be addressed particularly to physicians, businesses, private duty registries and other potential employers of nursing personnel, as well as to the public in general.

In addition, the Department of Health could provide, on a very large scale, short courses in simple physical nursing care, and make it as easy as possible for all unskilled nursing personnel to take them. A central objective of such a program would be to make such people aware of when to call for trained assistance. This would have the effect of reducing the numbers of totally ignorant people who are now employed to look after sick people.

With regard to the particular problem of nursing homes, it would be worth investigating the possibility of restricting the type of patient which could be admitted to a given home in accordance with the number and qualifications of nursing personnel available in it to provide care. This would result in different “classes” of homes, with each class legally limited as to the type of patients they could admit on the basis of the severity of the patient’s condition. Each class would then have to have an appropriate number and mix of nurses with various types of preparation.

Problems of Supply and Demand in Nursing

Problem 1

There is an acute shortage of detailed sophisticated and continuing analyses of the supply of and demand for nursing personnel on an occupation-wide basis.

Details

Though many wide-ranging and costly policy decisions have already been made on the assumption that there is and will be a severe, general shortage of nurses, the data on which these decisions have been based are extraordinarily insubstantial:

- 1) There are no integrated studies of demand based on all major nurse-employing agencies; and none which combines, within the same framework, detailed analyses of both supply and demand on a province-wide basis.
- 2) There are no studies which integrate the demands for all major *classes* of nurse — that is, R.N. (with degree); R.N. (diploma); R.N.A.; orderlies and aides.
- 3) Broad surveys of “hours of care per patient per day” in hospitals show no decline in quantity of care. Another study based on the ratio of nurses to hospital beds shows a surplus or shortage, depending on whether the “acceptable” ratio is assumed to be .43 or .50; yet there is no widespread agreement on which criterion is in fact acceptable. Studies revealing a slowly changing ratio of R.N.’s to R.N.A.’s and other classes of nurse do not analyze whether this is due to a shortage in supply of R.N.’s or a reduction in demand based on a desirable shifting of functions to non-R.N. personnel.
- 4) Studies of future supply and demand are based on several assumptions, the validity of which is subject to considerable disagreement.
- 5) There are no studies which attempt to pinpoint *specifically* where shortages are the most acute. This leads to potentially erroneous conclusions concerning how best to end any shortages indicated in broad studies. (For example, if shortages are the most serious in certain special types of hospitals such as chronic care and mental institutions, or in certain areas such as remote rural locations, it is questionable whether producing more young, single, female nurses from new and enlarged nursing schools will solve them.)

Reasons for the Problem

The main reason for the inadequate analysis of nursing supply and demand is that, until very recently at least, key governmental policy-makers whose decisions affect this area have not felt any need for them. They have understandably felt

they knew enough about the situation because "everybody" (individual hospital administrators, officials of the Ontario Hospital Association, and some nursing leaders, not to mention the newspapers and other media) had told them there was a severe general shortage which was only going to get worse. With so much "evidence", who needs to waste time and money doing a lot of complicated surveys and analyses?

There has been no *single* body responsible for studying supply and demand for all types of nursing personnel in all types of employing agencies, on a province-wide basis. The OHSC is responsible for hospitals and has concentrated primarily on the demand side of the equation, as has the OHA; the RNAO and College of Nurses have been interested almost solely in the supply side. Only since 1967 has the Department of Health begun to recognize a general responsibility in the area of overall manpower resource utilization, heretofore concerning itself primarily with supply and demand in public health agencies.

Among all those organizations and associations interested in nursing supply and demand, there have been grossly inadequate numbers of qualified manpower resource experts to carry out such studies, as well as a lack of modern data collection and analysis systems and equipment.

Approaches to the Problem

There should be created a centralized manpower resources research group to conduct detailed and continuing studies. This group should probably be based in the Department of Health and should probably be responsible for all health-related occupations. There should, however, be a unit within the larger section concerned particularly with the very large occupational group of nurses. It is vital that the members of such a research unit be made up not only of statisticians and manpower economists, but also of some representatives of the occupation itself.

Similar manpower research groups should be set up or expanded within the OHSC, the OHA and the RNAO. These groups would work closely with centralized research operations in the Department of Health. They would concentrate on more detailed studies and provide expert advice and information on how best to predict and measure supply and demand in the areas where they have special competence and experience.

Systems of information gathering and analysis must be redesigned so that appropriate and meaningful data are obtained. For example, staffing data reported by hospitals should permit distinctions to be made between budgeted positions temporarily vacant and those chronically vacant. Data on nursing supply gathered by the College of Nurses should contain information on each registrant's qualifications, previous work experience, present employment status, and area of residence. Such information, if properly utilized, could be fed to specific employing

institutions to aid them, if necessary, in recruiting. A thorough investigation should be launched immediately into the use of computers for storing, tabulating, and analyzing data on supply and demand. Only in this way will it be possible to get rapid, accurate, detailed breakdowns of the problem by region, type of employing agency, and occupational group.

Finally, equal attention must be paid to the dissemination, interpretation and use of the results of manpower studies. Too much valuable research is wasted because it goes to the wrong people at the wrong time, who are unable to understand its implications. The heads of manpower research groups must maintain constant liaison with the key policy-makers, so that the latter will be involved in defining what is needed in the first place and will be made aware of the meaning and limitations of what is eventually produced.

Problem 2

Details

Although there does not seem to be a serious general shortage of nurses at present, there *may* be

- 1) A temporary shortage in some large urban areas (such as Toronto) over the next three years as a result of the completion of planned hospital expansions and consequent sudden and rapid increases in the number of beds.
- 2) A chronic shortage of all types of nurse in some remote, rural areas.
- 3) A chronic shortage of all types of nurse in certain specialized types of hospital such as chronic care and psychiatric hospitals.
- 4) A shortage of some particular subclassifications of nurse — that is, specially trained public health nurses, nursing service administrators, nursing school teachers, psychiatric nurses and trained orderlies.
- 5) A general shortage of all types of nurse during the mid-summer months of July and August.
- 6) A chronic shortage of certain types of nurse in a few specific hospitals which have acquired "bad reputations" as places to work.

Reasons for the Problem

Why it is felt that there will be a severe nursing shortage. We believe that the feeling of shortage in nursing is created by the high turnover in this occupation, coupled with changes in the composition (though not the quantity) of supply. High turnover among nurses in a given organization involves administrators in a continuous search for replacements, and continuous problems of orientation and training of new staff. For those who do not stop to analyze the situation, it seems that nurses are an unending problem. The continuous effort expended

in recruiting and training is easily "explained" as being due to a shortage of nurses, in spite of the fact that replacements are relatively quickly found for those who leave.

There is also a lingering feeling of discontent among many nursing service directors and hospital administrators over the hiring of larger numbers of part-time, married and immigrant nurses. All these types, whose numbers are increasing in the total supply, involve special problems for administrators, who must devise new and more flexible work scheduling systems or special training and supervision during the initial period of employment. Many administrators do not have the time, money, special staff, knowledge or desire to make the accommodation necessary to these changing sources of supply. They yearn for the young, single, recently trained and easily controlled female nurse. Since they may not be able to find enough of these, the conclusion is that there is a shortage of nurses.

Finally, the feeling of a severe general shortage may be engendered by the existence of some very specific types of shortage such as those discussed below. It should be emphasized that the severity or even the existence of these specific shortages is not at all clear, due to the lack of research discussed on page 213.

Why there are present or future shortages in particular geographic locations. In the case of rapid, short-lived expansions in hospital facilities in urban areas like Toronto, the reason for possible temporary shortages developing is obvious. The major sources of supply, nursing schools, are simply not equipped to vary their intake to meet such exigencies. Nor, one could argue, should they be, if the rate of hospital expansion is only temporarily high, since this might lead to an unnecessary and costly surplus once the emergency is over and the rate of expansion contracts to normal.

With regard to the possibility of chronic shortages in remote, rural areas, the most likely reason is the reluctance of young, single women to live in such areas for any length of time (if at all) due to the lack of "husband material" and appropriate recreational facilities. This lack of attraction is probably coupled with a relative scarcity of older, married nurses in such sparsely populated locations.

Why there are shortages in chronic care and psychiatric hospitals. The primary difficulty here lies in the type of nursing required in such specialized hospitals. In general, it appears that most nurses prefer work which involves variety and full use of their skills (and even an opportunity to acquire new skill and knowledge); attending patients who show signs of progress in recovery; attending different types of people (men, women, old, young) and preferably people with similar cultural values to their own regarding sickness and self-care (people who are neat and cooperative, who bear their illness well and make an effort to help themselves as much as they can). As might be imagined, these characteristics of work are not present in chronic care and psychiatric hospitals — at least not to the same extent as they are in public general hospitals. As a result, the incentive to join such hospitals is low for a large proportion of the nursing force.

Why there are shortages of specific subclassifications of nursing personnel. The major reason for the shortage of specially trained public health nurses, nursing service administrators, and nursing school teachers is the failure of post-basic training programs, located in the universities, to supply adequate numbers. These problems of numbers of university program graduates will be discussed in detail in the section on nursing education (page 229).

There may be a certain number of nurses with qualifications to perform these specialized nursing functions but who choose not to do so because the rewards are not great enough. Inadequate salaries are the major deterrent to getting such people back to work, according to various nursing leaders we asked about the problem.

Because there are so few opportunities to obtain specialized post-basic training in the province, it is difficult to test the hypothesis advanced by some writers that nursing administration and teaching require a greater career commitment and entail more responsibility than most nurses are willing to undertake. This theory concludes that even if it *were* extremely easy to obtain the necessary post-basic training, there would be an inadequate number of applicants for the special programs. At the moment, this appears to be one of those problems that will have to be faced if and when it has an opportunity to arise.

In the case of trained orderlies, the shortage of qualified men is due to both inadequate opportunities for training and salaries not being competitive with those offered in alternative occupations available to the calibre of men suitable for trained orderly positions.

Why there are "summer shortages". For both married and young single nurses alike, there is a strong temptation to "take the summer off". Married women with children who are not fully dependent on their employment income find it convenient to leave their jobs when their children finish school. This enables them to look after their children while they are at home all day, and to have maximum flexibility in taking vacations when their husbands do. Single women who are not necessarily motivated to work solely by the desire for money may be willing to live on their savings and spend less in order to have longer vacations than those permitted by their employers. The temptation to do this is well supported by a definite norm among young nurses that it is a good and desirable thing to travel and "see the world". Appetites are further whetted by the tales told by co-workers from Australia, England and other places who are themselves doing the same thing. Since there are few, if any, special incentives to stay on for the summer and since there is no difficulty in obtaining another position in September, why not take the time off?

Why there are shortages in "bad reputation" hospitals. Though there is little direct, systematic evidence available, there appears to be an excellent "grapevine" in large segments of the nursing profession. As a result of the very high mobility

of nurses, stories of poor treatment in certain hospitals "get around" with great speed and no doubt considerable colourful elaboration of detail. One hears lurid stories of "bitchy" nursing directors or supervisors, "snarly" doctors, excessive work loads, inadequate supplies and equipment, "poor food", overly strict residences, substandard pay, "unfair" work schedules, and the like. When several of these complaints accumulate with regard to a single hospital, it quite understandably acquires a bad reputation either locally or, in a few cases, provincially or nationally. Nurses who hear about it shun it, and those who join it in ignorance soon leave. Once such a reputation is established, a self-fulfilling prophecy may be created in which the difficulty in obtaining staff exacerbates the problems which created the reputation in the first place, thus perpetrating the recruitment problem.

Approaches to the Problem

Approaches to increasing supply. These are some general approaches that can be made towards increasing the overall supply of nurses:

- 1) Reduce demand through more efficient utilization of existing nursing resources (discussed on page 40 above).
- 2) Increase the output of diploma schools of nursing. This has been the preferred and virtually only solution to be advanced and implemented on a province-wide basis by chief policy-makers in the OHSC and the Department of Health. It is an extremely expensive, complex and time-consuming solution, as can be seen in Part Two of this report. Relative to these costs it is far from certain that it will be sufficiently effective in alleviating most of the specific shortages which have already been identified. Although it will doubtless have some effect on them, it could well be a minimal one so long as there is a plentiful supply of jobs outside the province to which young graduates can go.
- 3) Mount a major program to attract back a substantial proportion of the 13,000 or more trained and registered nurses who are not now employed. Such a program would entail:
 - a) Provincial government sponsorship or at least provincial government financial support to organizations such as the College of Nurses, the RNAO or the OHA, who would be responsible for operating the recruiting program.
 - b) Conducting a large number of short refresher courses for retired nurses of all levels (R.N. and R.N.A.). Such courses should be available at convenient locations throughout the province, given on convenient dates and at convenient times of day. They should require no expenses on the part of the participants. In fact, a monetary incentive for attending might

be offered, if necessary. Preliminary studies should be done quickly to ascertain the best locations, dates, times and incentives for attracting participants.

- c) Studies begun in the Research and Planning Branch of the Department of Health to ascertain what it would take to attract non-practising nurses back to work should be expanded, intensified and accelerated. They should include identification of the age, experience, years since last employed, and residence of non-working nurses. Such information would be available from the College of Nurses if their records were computerized.
- d) As a result of the above studies, a large-scale, professional, provincially financed recruiting campaign should be launched. It should combine a centrally prepared publicity campaign with special efforts at the level of the individual employing agency — a structure similar in many ways to the marketing efforts of automobile manufacturers and their local dealers.
- e) The expanded consulting service of the OHSC should make a special project of the problem of devising improved systems of work scheduling so as to accommodate more part-time nurses in the hospitals; and then assist hospitals in the process of adopting and implementing these systems. While part-time employees are not necessarily less committed and capable in their work than full-time, nevertheless special attention must be paid to the creation of administrative practices within the hospitals which make the part-time employee feel a needed and responsible person.
- f) The provincial government should make every effort to persuade the federal government to permit tax deductions for the cost of child care and housekeeping while married women are employed.
- g) Finally, there should be set up, as soon as possible, a "Nursing Reserve" group, such as has been created in Alberta.² This system is ideal for obtaining the services of retired nurses who do not want to commit themselves to working regular hours, even on a part-time basis, but who are still willing to do some work. The scheme works on a principle similar to that of supply teachers for the educational system. The pool of reserve nurses can be called upon in emergencies, or to help overcome shortages due to unexpectedly heavy absenteeism or turnover, or to provide relief for staff during the troublesome summer months.

²All credit for this idea must go to Dr. J. D. Wallace, Executive Director of the Toronto General Hospital, who was the originator of the Alberta plan.

The reserve nurse system is more than just a list of names, however. Effort is made in Alberta to give the reserve nurses an identity and purpose. Refresher courses are provided if necessary. The nurses are given distinctive shoulder flashes on their uniforms to identify them. They have been encouraged to form an association which engages in various social and professional activities, including the publication of a newsletter.

This group structure creates a morale which far surpasses that developed by the person-to-person form of recruiting of retired nurses now used. Retired nurses in Alberta have had a chance to try nursing again without committing themselves and with full support from others in the same boat. Many have gone on to assume regular full-time or part-time positions.

The one problem with the reserve nurse system is who should control it. It is suggested that it would be best organized within the Department of Health, but on a regional basis. Perhaps a special unit within the Department could be set up to centrally plan and guide the introduction of the scheme and organize the necessary refresher courses. Actual implementation of this plan would then be the responsibility of an appropriate regional body.

- 4) Amend the provincial Labour Relations Act in accordance with the British Columbia model so as to permit the Registered Nurses' Association of Ontario to act as a legal bargaining agent for nurses.

Province-wide bargaining between the RNAO and Ontario Hospital Association should be encouraged. Also, the RNAO should be encouraged to merge with the Ontario Association of Registered Nursing Assistants so that it may be the bargaining agent for all formally prepared nurses.

The main effect of province-wide collective bargaining in nursing will be to eliminate inequities in wages, hours and working conditions among employing agencies. These improvements may lead to increases in supply.

Representation of nurses at the local level, whether or not it is a part of a province-wide collective bargaining system, will serve to increase upward communication to management (through the grievance and negotiation procedures) and may result in improved administrative practices.

- 5) Increase wages. Although nursing salaries have increased substantially since 1965, they remain low compared to those of teachers — a group with whom, rightly or wrongly, a large number of registered nurses compare themselves. Wages should be increased on a basic, across-the-board fashion, by inaugurating differentials for shift

work, overtime and holidays; by raising the maxima which can be paid at each level; and by widening the differences between levels. These approaches are elaborated at appropriate points in the discussion of specific shortages below. The main effects of improved wages will be to keep more nurses in the labour force, attract retired nurses back, and lure nurses from other jurisdictions.

- 6) Mount a major program to attract men into nursing. Although the desirability of having more males in nursing is almost always stated by all interested parties, there has never been a truly large-scale, integrated, province-wide drive to attract them. Such a program would have to involve creating and publicizing an acceptable image of the male nurse; and setting up one or more all-male or at least majority-male schools of nursing, partially — if not completely — staffed by male teachers.

It may be possible to do this within the context of one of the new community Colleges of Applied Arts and Technology. The initiative to undertake all this might have to come from the OHSC, the Department of Health, the OHA or some other non-nursing organization; for the nurses, themselves, for all their talk, are not willing to engage in large-scale efforts to attract men into their profession.

The College of Nurses has recently begun to facilitate the registration of foreign-trained nurses by relaxing the regulations requiring that some such nurses, when judged deficient in some aspect of training, need to take special courses before being allowed to write an examination in the subject. State registered nurses trained in the United Kingdom will be permitted to write the examination directly. This practice will be extended to other cases if the experience with the change is favourable.

Organized bodies of nurses in Canada as a whole should take the lead in the International Council of Nurses in working towards the development of a world-wide agreement on qualifications for practice, in order to facilitate the international mobility of nurses.

The College should also investigate the possibility of creating an "endorsement system" with at least some other provinces, as the basis for giving non-Ontario trained nurses their registration in Ontario. The present process is cumbersome and may well discourage some nurses from coming to Ontario.

Finally, both the College and RNAO should actively support the efforts of the Canadian Nurses' Association to develop uniform standards of registration throughout the whole of Canada.

Approaches to increasing the supply of nurses in specific geographic locations. With regard to temporary rapid increases in the numbers of hospital beds, there

is little that can be done to supply a sudden demand; at best the new nursing units can be designed so as to reduce the numbers of nurses needed, and then massive recruiting drives can be mounted, aimed at out-of-province nurses and particularly at retired nurses in the locality. Such programs must make special provision for retraining as needed. This, in fact, is what a number of Toronto hospitals, with help from the OHSC, the RNAO and the OHA, began to do in late 1967 to get over their imminent period of rapid expansion.

In chronically understaffed areas a similar approach must be followed. On the one hand, the local employing agencies must make a thorough census of all qualified personnel in the area, be ready to approach each nurse individually if necessary to see what would be required to get her back to work, and then make every effort to meet these needs. The regional Councils of Health currently being developed by the Minister of Health might be suitable bodies to sponsor the localized manpower surveys which would form the first step in this process. Special assistance from the enlarged OHSC consulting service would prepare the employers to improve their attractiveness to the unemployed identified by the survey.

The other major strategy for the remotely located short-staffed employers is a system of special incentives to bring nurses to them. The most effective of such incentives would be additional salary, but there may also prove to be value in offering such "fringe benefits" as attractive residence accommodation, travel allowances once or twice a year to pay for a woman to return home or go into the nearest city, slightly longer vacation periods, and the opportunity to take annual vacation time on two separate occasions.

Finally, the chronically short areas would want to look carefully at their skill mixes. Expert nursing consultants should ascertain whether the nature of the illnesses treated in the hospital, for example, would permit the use of more R.N.A.'s and fewer R.N.'s. Since the R.N.A. labour market is more local than that for R.N.'s, there may be more of this type of nurse available. In severe cases, it may even be possible to recruit older women of suitable potential but no training and pay them to take a ten-month R.N.A. training program at the nearest training centre.

Approaches to easing shortages in special hospitals. One approach in chronic care and psychiatric hospitals which has considerable merit is that recently begun at the Hamilton Health Association hospital. The hospital began its own training program to create nursing assistants (not qualified R.N.A.'s) specializing in the nursing of chronically ill patients.

One of the clinical specialties which might emerge at the R.N. level might be psychiatric nursing, as well as chronic illness nursing or perhaps geriatric nursing (many of the patients in chronic care hospitals are elderly people suffering from varying degrees of senility). *If* such a development took place, it might create a feeling of interest and pride in this arduous and relatively unexciting kind of nursing.

If the problem becomes much more severe, it may be necessary to provide special incentives for nurses to work in these unique settings. Aside from the obvious use of money differentials, there is particular value in developing the concept of "participative management" to the full in these hospitals. This approach to leadership involves maximum involvement of all levels of personnel in the making of decisions which affect them and their work.³

Finally, research should be undertaken to establish the possibility of improving employee selection techniques in these hospitals, so as to increase the probability of finding staff with a particular aptitude and interest in the nursing of mentally disturbed or chronically ill patients.

Approaches to easing shortages in nursing subclassifications. As previously indicated, the main reason for a shortage of public health nurses, nursing teachers and nursing service administrators is a lack of opportunity to acquire the specialized education that is necessary. The solution obviously is to create more such opportunities. Approaches designed to do this will be discussed in the section on nursing education.

The only additional approach which would enhance the incentive to enter these nursing specialties and to stay in them would be larger salary differentials. It seems incongruous, for example, that nursing school teachers should receive no more than most head nurses (the first line supervisory level in nursing administration); and that many head nurses make very little more than the general duty nurses they supervise and sometimes even less than high seniority non-supervisory nurses.

In the case of orderlies, if there is a definite need for these men trained at the level of R.N.A.'s, it is essential first to clarify their position as mentioned previously, and then to provide substantial wage increases to attract and retain suitable people. The supply of ex-military medical assistants who once formed the core of the skilled orderly force in hospitals is almost gone. New recruits of quality will not be attracted into the occupation unless it is completely and radically overhauled.

Approaches to easing "summer shortages". Unfortunately this will probably always be something of a problem, even though the severity of it remains to be established by specific studies. If the problem proves in fact to be serious, the following approaches could be tried as a means of motivating more nurses to stay on for the summer months:

- 1) Introduction of special "summer stipends" or bonuses for the summer months (similar to the "extra pay" given to teachers who teach summer school).

³For simple descriptions of this approach and discussion of its benefits, interested readers should see D. MacGregor, *The Human Side of Enterprise*, McGraw-Hill, New York, 1960, and R. Likert, *The Human Organization*, McGraw-Hill, New York, 1967.

- 2) Introduction of longer vacations (perhaps three weeks) and encouragement of people to take them staggered over the year.
- 3) Introduction of substantial pay increases for nurses who remain twelve months or longer with the same employing agency.
- 4) Initiation of studies to develop more systematic and formal plans for making better use of *both* senior level nursing students *and* teachers, especially in university nursing schools. At least one hospital visited had considerably eased its summer shortage problem by conscientiously seeking out university nursing students and arranging special summer jobs for them.
- 5) In particular the discovery and encouragement of summer recreational programs in the area and making single, female nurses aware of this.

Approaches to the problem of hospitals with a "bad reputation". The particular actions necessary to overcome a "bad reputation" which is keeping nurses away from a particular hospital depend on a detailed analysis of the specific conditions creating the problem. In general what is usually needed to effect a "quick turnaround" in the situation is a major upheaval in the institution, a thorough shakeup of the hospital management from top to bottom. The major value of such a dramatic and sudden overhaul is psychological — it creates the feeling of a "new era", wiping the slate clean. Of course, once such a shakeup is begun, the changes made must actually improve the specific faulty conditions; but if the conditions themselves are changed in only a gradual and moderate fashion, it will take some time before the news of them gets around and the tarnished reputation is refurbished. What is wanted is the equivalent of the effect produced in a community by the sign "under new management" placed in the window of a once popular shop which had steadily gone down hill.

Problem 3

The rate of employee turnover in nursing is unnecessarily high.

Details

One of the reasons why hospital administrators get the feeling there is a terrible nursing shortage is that high staff turnover has an unconscious psychological effect on them. Studies differ slightly regarding the exact rate for R.N.'s, but it appears to be somewhere between 50 to 60 per cent per year on average in Ontario. Predictably, the rates differ widely from one subclassification of nurses to another. Turnover is highest among those just beginning their careers and among the young, single nurses (the two are obviously correlated). It is lowest among older, more senior employees and those in supervisory positions. It is also relatively low (32 per cent) for full-time R.N.A.'s, though quite high (58 per cent) for part-time R.N.A.'s.

It is clear that the greatest proportion of turnover is caused simply by the exigencies of nursing being a female occupation. Women have always been the most fluid segment of the labour market in Western society, entering and leaving it at various points in their lives; for example, entering after completing their education, leaving on getting married, perhaps entering again while they await pregnancy, leaving for childbirth, perhaps entering after the child begins school, but then leaving to have other children; entering again after all children complete school and finally leaving when they or their husbands reach retirement age. They also respond sensitively to economic fluctuations in the family, entering the market to earn "extra money" for special purposes then perhaps leaving again when these short-term objectives have been attained.

In spite of all this, it would seem that the turnover rate in nursing is anywhere from 20 to 30 per cent higher than in other all-female occupations, such as telephone operators, bank clerks and office clerical and secretarial employees. Why might this be so? And is there anything which might be done about it?

Reasons for High Turnover Rates

If we take as relatively irreducible a turnover rate of about 25 per cent per year for almost any predominantly female occupation, we can still ask why the rate for the main body of nurses — the general duty R.N.'s in hospitals — is so much higher than this.

There is no question that a certain amount of this above-average turnover is due to the "see-the-world" norm which pervades the ranks of young R.N.'s. Part of the initial attraction of the occupation is the chance it provides to get a respectable job almost anywhere in the English-speaking world. When a young girl feels the urge to move on, there is probably little that her employer can do to stop her.

Most employers seem to feel that with marriage, childbirth and travel, very few reasons remain for leaving a hospital. Nurses themselves foster this belief when they leave by drawing on these common reasons even though, in fact, they might have stayed on longer had their jobs been more attractive to them.

Since hospitals *do* vary from one to another as to their turnover rates, it is important to study closely both the very high and the very low turnover employers in an effort to find out why. This would be yet another job for the enlarged OHSC consulting service. It may prove to be that the low turnover hospitals have managed to attract a high percentage of the more stable older women. But it may *also* be that the administration has implemented policies which enhance nursing job satisfaction to the point where staff are unwilling to leave. Some of the specific practices which might lead to this high job satisfaction are discussed below.

Approaches to the Problem of Reducing High Turnover

Every employing agency of any size should be instructed in the simple steps involved in conducting regular, continuing and detailed studies of staff turnover in their organizations. Sudden fluctuations in this rate are often symptomatic of morale problems and need to be investigated. A regular practice of conducting employee job attitude surveys also would help to reveal potential troublespots which could show up as excessive turnover before it happens. The leaving interview by itself, no matter how well conducted (and it usually is *not* well conducted), is not a reliable indicator of the reasons for turnover.

Detailed longitudinal studies of short-term and long-term employees in each organization will also reveal the characteristics of the most mobile types of nurse in the organization and of those most likely to stay. This information can be used to improve the efficiency of recruiting programs, so that they may be directed strongly at attracting the stable type of nurse.

Job attitude surveys would also reveal those aspects of the job which nurses find the most annoying, frustrating and upsetting. Studies in industry and among other types of employers of highly skilled "white-collar" technical and professional employees indicate that such employees are more likely to want to stay in the organization when they are given a high level of autonomy in the performance of their work; when they are given a voice in the making of decisions which affect them; when they are supervised in a considerate manner; when there is a high level of opportunity for interaction and consultation among peers; when they are provided with opportunities to improve their professional competence; and when there are plentiful opportunities for advancement in pay and responsibility *within* their area of specialization (in other words, administrative positions are not the only road to advancement).

Specific studies need to be done to ascertain the extent to which the above conditions would serve to keep general duty nurses longer on their jobs; but at the very least one can think of specific policies which would lead to the sort of atmosphere described:

- 1) Development of the team nursing concept in its ideal form would increase autonomy, foster interaction, and promote professional development.
- 2) Increased opportunities for in-service training would increase professional development, permit greater autonomy, and make staff more capable of contributing to the decision-making process.
- 3) Creation of a dual-ladder of promotion in which nurses can obtain higher salaries and greater responsibility in technical-clinical specialties, as well as administration, would provide strong incentive for remaining with a given employer.

Problems of Nursing Education

Basic Problems of Province-Wide Policy

First, while it may be that *minimum* standards of education for the various levels of nursing are *generally* being met today, the differences between schools within each level in matters affecting education quality and the differences in rates of improvement between schools are too large.

Second, the overall rate of increase in numbers of all types of graduates *may* be too slow; it is definitely too slow at the university level.

Details

In citing extreme variation in various aspects of nursing education as a province-wide policy problem, we do not mean to imply that *all* differences between nursing schools are bad; or, conversely, that there should be complete uniformity in the nature of the educational process within each level of nursing. On the other hand, it is true that certain of the aspects on which there is variation will have a considerable impact on the quality of the graduating nurse and may affect the costs of education. Because of this, at the very least, variations must be closely studied and the most divergent at the low end of the scale must be helped to meet a minimum standard.

Some of the areas of nursing education which are critical to quality and reveal widespread variations are discussed below.

In R.N. diploma-level education. The crucial factors are total program length; length of clinical learning experience; and adequacy of clinical facilities in terms of amount and quality.

There is still considerable divergence over how long it should take to educate a diploma-level nurse and how much of her education should be in the form of clinical experience (providing actual nursing care to genuine patients or clients). Though the trend is away from three-year to "two plus one" programs, this represents primarily changes in sequencing of content and, to some extent, control of the school (from hospital to independent or semi-independent boards). It is the change from "two plus one" to two-year programs which typifies the major discrepancies in length of the total educational process and amounts of clinical experience needed. Furthermore *within* both two-year and "two plus one" programs, the amount of time spent in clinical experience varies considerably from school to school. There is also great diversity from school to school in the breadth of clinical experience available and the quality of these experiences.

The main problem is that two-year as opposed to "two plus one" programs apparently turn out a slightly different type of nurse — graduates of the former program may need about four months' "seasoning" in the sense of closer super-

vision and guidance on the job before they can function at the same level as the newly graduated "two plus one" nurse. The province must decide which program to adopt and move towards it at all possible speed, so that service organizations can make the necessary adaptations. In the process, gross discrepancies between schools in amount of clinical experience provided should be studied, and hopefully the variation should be narrowed.

In spite of the basic minimum curriculum laid down by the College of Nurses, there is still considerable variation from school to school in the actual subjects taught and in the way the content of the program is organized and presented. This variation should be controlled, in that there should be a central body aware of it and attempting to measure the effects on the quality of education received. Should student nurses be taught, for example, medical sociology, techniques of team nursing, operating room and emergency ward nursing, and public health nursing? And, if so, how much and in what fashion should such subjects be presented? How much in the way of general education in science, the humanities and social sciences is desirable; and what, in particular, should be taught and by whom? The vast array of answers to such questions as these now represented in the province's schools needs examination and coordination, so that eventually some conclusions may be reached.

It is still not clear what the optimal size for a nursing school should be in terms of numbers of students and facilities. This must be analyzed in relation to both cost and educational effectiveness. The concept of regional schools has been developed; but rather than resulting in a large-scale consolidation and hence reduction in the number of existing schools, a large part of it has simply been imposed on top of the existing system, resulting in an even wider divergence in sizes and facilities.

Teacher effectiveness varies greatly from school to school as a result of widespread differences in teacher qualifications, student-teacher ratios and the number and kind of duties and responsibilities given to the teachers.

Finally, there is considerable variation in admission standards, and recruiting and admission procedures. The Nurses' Act specifies minimum qualifications for admission to nursing schools, thus implying that there is a high probability that an applicant who meets these qualifications can handle the curriculum and will make a satisfactory diploma nurse. In spite of this, schools may require or prefer applicants to have varying degrees of preparation beyond the allowable minimum. Such variation *may* be desirable if the curriculum is demonstrably more demanding than average. At present, however, there is no attempt to govern the admission policies of individual schools according to any such criteria. As a result, the applicant who just meets the minimum legal standards is unlikely to gain admission. Furthermore, existing application processing procedures result in a situation where some applicants, qualified for admission to some schools, may not enter nursing

because they applied to the wrong (for them) school. Other *potential* applicants may never attempt entry because of inadequate recruiting procedures in the area in which they live.

Variation at the R.N.A. level. The amount of diversity between individual R.N.A. training centres is difficult to establish. We did not have the time to gauge it in our study, and those responsible for maintaining the minimum standards laid down in the Nurses' Act do not have the time to do more than perform the basic inspection. It was our impression that there is high similarity between training centres operated by the Department of Health and by the Department of Education (in secondary schools), but that considerable variation may exist in the thirty-four centres operated by individual hospitals. As before, the immediate problem is assessing the exact nature and extent of this variation and estimating the effects of various practices on the cost and quality of education produced.

Variation at the university level. The variation in the components of the educational process to be found within the university level is slight.

All eight universities with schools of nursing are rapidly moving towards a standard set of offerings and a standard program structure (four years, integrated for diploma-trained R.N.'s; no certificate training other than for public health). Admission standards are similar. The primary differences lie in size, facilities and faculty qualifications as between the older, established schools and the newer ones. There are also natural differences between the schools now offering or about to offer postgraduate degree programs and the remainder.

The "numbers" problem. In the case of R.N.A.'s and diploma-trained R.N.'s, the extent to which one feels there is a shortage of graduates depends very much on one's belief about overall supply and demand; and the extent to which one believes that supply could and should be expanded by drawing already-trained nurses back into the labour force. As described elsewhere in this report, the provincial government has already decided that there is a severe general shortage of R.N.'s and R.N.A.'s, and that the main solution is to double the numbers of graduates from diploma schools and R.N.A. training centres by 1971. Even if one accepts this goal as desirable, the fact is that the current and expected rate of increase in graduates is very slow and the goal will not be met. The expansion of existing schools and the creation of new schools or merging of two or more existing schools into a new entity has not progressed particularly fast since the decision to increase enrolments was made in 1965. On the other hand, a number of expansion plans which have for a long time been in the stage of formulation are now at the implementation stage; and this, coupled with renewed pressure from the Minister of Health beginning in July 1967, may well bring about a significant increase in enrolments over the next three years.

A more serious "numbers" problem exists if one believes, as virtually all nursing experts do, that nurses specializing in teaching, administration and public health

require some formal educational preparation beyond diploma training. If nursing schools expand as planned, a minimum of 300 new teachers will be needed by 1971; and to produce them university schools will have to expand *their* enrolments rapidly. In the case of nursing service administrators, the vast majority do not now possess specialized training, and the number of administrative positions created by the planned increase in hospital facilities simply adds to the problem. The demand for expanded community health services also appears to be great, causing an increased need for public health specialists.

In educational terms what these shortages of qualified people mean is that the universities are not providing enough opportunities to obtain this training. They have already ceased, or are about to cease, offering the one-year certificate courses which provided the main form of post-diploma education in the past. They have, at least temporarily, discouraged many diploma-trained R.N.'s from returning for their baccalaureate degrees by lengthening the time required from two years to three; and the enrolments for the four-year baccalaureate programs are not rising very rapidly at all. Finally they are having a very difficult time enlarging postgraduate degree opportunities. Without doubt the slow development of university programs in nursing is the most serious problem in nursing education today. Until it is improved, neither the quantity *nor* the quality of nursing care can be improved; and if only one is concentrated upon, it cannot be changed without adversely affecting the other.

Reasons for the Problems

The primary reason for the variation between schools within each of the levels of nursing education is the degree of decentralization of decision-making authority. Each individual school is free to decide matters of program length, amount of clinical experience, subjects taught, admission standards, and faculty qualifications and duties beyond the minima laid down in the Nurses' Act. They are also subject to unique constraints on their authority in the form of the clinical and other facilities available within reasonable distance from the school and the budgeting allowances made to them by the Ontario Hospital Services Commission. (Thus a given school cannot enlarge the clinical facilities or public health agency experiences available to its students if the nearby hospitals and agencies cannot or will not admit them; nor can they expand unless the OHSC is willing to supply the necessary money.)

Another condition which contributes to the variation is that the two bodies which possess ultimate authority for education, the OHSC (which controls funds and, thereby, how money will be spent) and the College of Nurses (which controls educational standards), have either not had the desire or not had the staff to provide extensive advice and guidance to individual schools. Furthermore, until very recently, there has been very little integrated planning and consultation on a continuing basis between the College and the OHSC. As a result, many of the individual schools have been subjected to pressures from both sides to under-

take, simultaneously, both changes in the structure of their programs and an expansion or consolidation with other schools. Each school has reacted to these pressures in its own way: some have done nothing, others have emphasized the structural and content changes, while still others have emphasized expansion or merger arrangements. Some have moved relatively quickly and others relatively slowly. These idiosyncratic reactions to pressure have been due both to the local circumstances of the school and the lack of coordinated aid from the policy-making bodies. A similar situation exists also for the various registered nursing assistant training centres.

The numbers problem in the case of R.N. diploma school enrolments is brought about by much the same forces which have created the extreme inter-school variations in content and structure. Each school decides whether or not to accede to requests from the OHSC to expand or join other schools in forming a regional school. New regional schools must be "sponsored" by several hospitals. These hospitals may or may not be able to speedily arrange such sponsorship. The uncoordinated pressures from the OHSC and College of Nurses, plus the absence of plentiful assistance from these bodies, contribute to slow movement at the local level. Finally there is the extreme shortage of qualified teachers due to the difficulties experienced by the universities in increasing the numbers of degree graduates and their decision to eliminate the one-year certificate program in teaching.

At the university level, the problem has been caused by a complex interaction of a shortage of faculty, inadequate budgets, a shortage of clinical facilities, and a general tendency on the part of senior faculty in the nursing school to attend first to problems of quality—the structure and content of their offerings—before responding to demands for sheer numbers.

Approaches to the Problems

The root cause of both the major problems in nursing education are the same: the amount of decentralization of authority at local school levels and the lack of integration and adequate advisory resources at the provincial level. There are various approaches to trying to improve the situation.

The approach which is least different from the status quo involves:

- 1) Improving coordination between the College of Nurses and the OHSC so that they can better establish priorities, and generally plan the future development of schools in terms of both quality and quantity.
- 2) Considerable expansion of consulting services available to both R.N. diploma and R.N.A. training centres, so as to aid them (or pressure them) in conforming to overall provincial nursing educational goals. Perhaps the OHSC and the College could arrange a jointly controlled consulting group.

While the expansion of consulting services would no doubt improve matters greatly, there would still be difficulties with the integration problem. The coordination and cooperation between the two bodies would be completely voluntary, and each side would feel obliged to represent its particular interests. "Joint committees" of this kind have broken down or fallen into disuse in the past.

Also, the making or approving of the final policy decisions would still be in the hands of the senior levels of the OHSC and the Department of Health (represented by the Minister, Deputy Minister and Council on Health). It is they who may amend the Nurses' Act and who control nursing school financing. In our study it was concluded that, at least in the last three years, the users of nursing resources have perhaps had disproportionate influence at these top levels relative to the nurses.

The final difficulty with this first alternative is that, in the last analysis, the individual schools remain perfectly free to disagree with and resist any or all provincial policies on education, so long as they meet the few minimum standards laid down by the Act. Of course, the OHSC, the College and other bodies can bring considerable informal or unofficial pressure on each school if they have to — much more than is used at present. But this can be both a long and needlessly subtle activity.

The two major questions embodied in the analysis so far are

- 1) How much *centralized* control should be exerted over the diploma nursing schools and R.N.A. training centres in the province? and
- 2) Whatever centralized authority does exist, where should it be based: in the College of Nurses? in the OHSC? in some other part of the Department of Health? a part in each of these (the present situation)? a single independent body financed through the Department of Health? or as a part of the post-secondary school system under the Department of Education?

The Ad Hoc Committee on Nursing Education in Saskatchewan answered this first question by concluding "that *one* authority must be assigned *total* responsibility for the education of nurses in Saskatchewan".⁴ The way in which this conclusion could be at least partially implemented with the least amount of change to the present system would be simply by increasing the authority of the OHSC and College of Nurses in the areas which concern them already. Thus the OHSC could *order* a given school to expand, contract, close or merge with other schools, and could have complete control over the internal disbursement of funds. The College similarly could issue orders on all details of program length, structure and content, faculty qualifications, admission standards and policies.

⁴Province of Saskatchewan, *Report of the Ad Hoc Committee on Nursing Education*, op. cit., p. 90. (Emphasis added.)

This would still leave the two bodies to coordinate and integrate their activities, and the Minister of Health and his senior advisors would still be in the position of final arbitrator of quality-quantity conflicts and ultimate authority on policy questions.

A slightly more radical approach would be to centralize authority under a *single* entity responsible for *all* matters of nursing education. This would overcome the potential problems of voluntary coordination between the College of Nurses and the OHSC. The question then would be where to place such an authority. If the Minister of Health were deemed to be the most satisfactory final authority, there are various approaches which could be taken. One would be to enlarge the scope of the College of Nurses by creating a Nursing Education Branch within it and amending the Nurses' Act to give it the requisite authority to decide all matters of diploma and R.N.A. education. Another would be to create a separate Nursing Education Branch within the Department of Health.

A third alternative would be to create a branch within the Department of Health responsible for the education of *all paramedical* occupations and include a Nursing Education group as a part of this unit. Such an arrangement would have the advantage of encouraging much-needed coordination and liaison between groups that ultimately are highly interdependent in their respective practices (especially in hospitals). Both the second and third of the above alternatives would probably require the creation of a separate Nurses' Education Act and the removal of all matters dealing with education from the present Nurses' Act.

The final alternative to the question of where to base a single central authority for nursing education is that advocated by official spokesmen for the nursing profession, the federal Royal Commission on Health Services and the Saskatchewan Ad Hoc Committee on Nursing Education. In the words of the Saskatchewan report: "The Committee concluded . . . that responsibility for nursing education should be divorced from the responsibility for nursing service."⁵ It then went on to recommend that the Department of Education be assigned the responsibility of the education of nurses and that a special division of nursing education be created under this Department with its own separate Board of Education and its own Nursing Education Act to administer the nursing education program.

The main problem in trying to evaluate the relative advantage of placing nursing education under Health or Education lies in estimating the relative influence of the forces representing quality and those representing quantity. It is simply impossible to predict to what extent the requirements of nursing service would be de-emphasized if education were located in the Department of Education; or conversely, to what extent matters of educational standards would be placed

⁵*Ibid.*, p. 90.

second to considerations of quantity in an educational system financed and ultimately controlled by the Department of Health.

Aside from this basically unpredictable question, most of the advantages probably lie with a system based in the Department of Education. Being completely cut off from the pressures of individual hospitals, it would be much easier to consolidate schools and make use of facilities and staff available in the newly developing community colleges (and secondary public schools in the case of R.N.A. training centres). This should result, at the very least, in considerable financial savings and, at best, in a considerably greater uniformity of educational standards.

Even more beneficial results could be expected if the education of all other health service occupational groups requiring post-high school training but not requiring university degrees could be brought under one wing — a Health Services Education Branch, for example. By such an arrangement it might be possible to work out common courses in basic health and social sciences, for example, which all types of students could take together in their initial period of training. Such coordination would not only save money but help form a common bond between all those choosing to devote their working lives to the maintenance of health in society.

The chief potential *disadvantage* of an educational system completely divorced from the sources of nursing practice (aside from the possibility of ignoring the need for numbers) is that the educators might grow insensitive to new developments and new needs among practitioners and those who employ them. This has already become a problem in the case of university-based nursing schools.⁶

It is slowly being rectified there as these schools become "integrated" (and thus do their own clinical teaching) and as faculty develop more interest in the teaching of clinical specializations. This potential danger would have to be circumvented at the R.N. diploma and R.N.A. level by means of a strong representation of both employers and service-oriented nurses on the critical governing bodies of the nursing education branch and at the local level (in the form of liaison committees with individual schools and centres). In addition, bodies like the OHSC and the Research and Planning Branch of the Department of Health would have to maintain a skeleton group of nursing education experts responsible for assessing the service needs of the major nurse employers, interpreting these in educational terms and ensuring that they are taken account of by the educational authorities.

Whichever of the above four main alternatives for controlling nursing education are chosen, the decision should be based on an evaluation of how well they are likely to meet the following criteria:

⁶See Fred Davis, Virginia L. Oleson and E. W. Whittaker, *op. cit.*, pp. 138-175.

- 1) The central controlling body and the regulations governing it must provide for an equitable representation of the forces oriented to the nursing needs of service agencies and those oriented to maintaining and improving the standards of the profession. It must also provide some machinery for the coordination of nursing education with that of other paramedical occupations requiring post-secondary education.
- 2) The central authority must be provided with adequate staff and budget to be able to offer sustained and detailed advice and assistance to each individual school or training centre as needed.
- 3) The machinery must be provided to ensure that recommended changes in educational matters are implemented with the greatest efficiency in terms of time and cost.
- 4) Any central authority must avoid becoming too enmeshed in the detailed operational procedures and practices of any larger bureaucratic structure of which it is a part.

The previous discussion has to do solely with improving the variation and numbers problems in the area of R.N. diploma and R.N.A. education. None of the approaches suggested would have any influence on these same problems at the university degree-level of nursing education. The primary issue at this level is how to facilitate the rapid expansion of specialized training for diploma school teaching, public health nursing and service administration, as well as postgraduate training for university teachers and researchers.

In the case of universities it is impossible to tamper with the autonomy of any part of them in the area of the structure and content of the program. This means there can be no centralization of authority at the university level. It is possible to make provision for more coordination, cooperation and information exchange both between university nursing schools and between the universities, the remainder of the profession, and the major service agencies using university graduates.

One alternative would be to give the individual schools the necessary financial and moral support to facilitate the rapid development of the nascent Association of Ontario University Schools of Nursing. This group should be encouraged to undertake a major program of gathering and disseminating information on all facets of university-level nursing education.

It could also strive to arrive at priorities in university nursing education and work towards an overall integrated plan of development for all the schools, so as to avoid unnecessary duplication and facilitate the most rapid increase in enrolments. Such priorities and plans would then have to be accepted by the individual universities. Third, a strong association would act as spokesman for all university

schools to the public and particularly to the sources of funds in the provincial governments, the hospitals, the remainder of the profession and associated disciplines.

Finally, the existence of such a body would provide a focal point to which service interests could direct their beliefs and recommendations concerning how the universities could best serve their interests. (Incidentally, in this regard, the various representatives of the profession and the employers must not hesitate to engage in detailed studies of the whole university nursing education process and speak their mind on this matter openly and directly. In the past, the universities have perhaps been treated with more deference and circumspection than is good for them. There is certainly nothing omniscient about university faculty.)

Another approach would be to create a coordinating, information gathering and planning service for university nursing schools under the aegis of the provincial Department of University Affairs, if such a unit were possible in this Department. Such a group would perform the same activities as those mentioned in the previous alternative (other than the public relations and "lobbying" function). It would have the advantage of being more closely connected with the sources of university funds and it would perhaps be better financed, better staffed, and more stable than a purely voluntary association. The chief disadvantages would be its inability to engage in large-scale public relations activities and the possibility that individual universities might resent such an entity being unilaterally created by provincial authorities.

The establishment of a central Institute for Nursing Research in conjunction with the province's first Ph.D. program in nursing, and closely affiliated with one of the province's universities (as recommended in the section on nursing practice), might also serve to smooth out some of the extreme variations from school to school. Similarly, the increase of detailed studies of nursing supply and demand (recommended in the section on supply and demand) would provide the universities with more and better data on which to base their plans and forecast their budgets. The increased research on practice and research on supply and demand would be utilized best if funnelled through a single planning and coordinating body for all university schools of the type discussed above.

Specific Problems of Nursing Education

So far, the discussion of nursing education has revolved around the broad issue of provincial policy on how best to control the educational system so as to minimize excessive variation in standards and provide adequate numbers of graduates. No matter what decision-making structure and process is created, however, there remain a number of specific problems requiring immediate action. Most of these have been identified, and the actions suggested, by other groups and individuals interested in nursing education. All are discussed in previous chapters of this report.

What educational experience to provide. At all levels of nursing, it is vital that students be taught: 1) the elements of psychological care; 2) the need for, and problems in achieving, coordination and cooperation between levels in nursing and between nurses and others with whom they must work. This means teaching the concept of team nursing. It means making them fully aware of the duties, authority, attitudes and expectations of those at other levels and in related occupations. It means teaching them the rudiments of medical sociology.

The amount and kind of in-service education now provided in provincial hospitals should be investigated immediately. In the area of in-service education in nursing there appears to be a definite need for:

- 1) A program of specialized training for directors of in-service education.
- 2) A reorganization of the in-service education structure within most hospitals so as to bring all those responsible for all types of education together as a single administrative unit.
- 3) More and better staff, facilities and budgets for the provision of in-service programs.
- 4) Provision of special orientation programs for nurses who have been retired for some years or who have been trained in a different country.
- 5) Provision of programs to bring graduates of two-year schools of nursing to acceptable levels of competence as quickly as possible.
- 6) Provision of programs to acquaint nursing practitioners at all levels with the nature of two-year nursing education and help them overcome some of their natural biases against it.
- 7) Provision of a program of "management development" for administrators and supervisors of all functional groups within hospitals and public health agencies.
- 8) Provision of programs of training in clinical specialization where needed.

There is a general problem of how much, and what kind of, clinical specialization should be formally taught in nursing. This is a fairly long-range problem because as yet the nursing profession is unable to agree upon the delimitation of areas of clinical specialization. Meanwhile, individual hospitals and other employers in the country carry out a de facto specialization of their nurses by organizing long term formal in-service programs (for example, in intensive care unit nursing at the Winnipeg General Hospital) and informal on-the-job training for senior staff who remain in a given unit for long periods of time. The universities are reluctant to offer clinical specialization at the baccalaureate level but are

slowly moving towards the preparation of such experts at the M.Sc. level. The diploma schools do not have the time to provide instruction in more than basic general duty nursing.

It may be that the universities will have to turn out the leaders in clinical specialties, while either the larger teaching hospitals or perhaps certain community colleges prepare specialized practitioners. In any case, a detailed plan for the provision of such training should be centrally devised, organized and implemented as soon as possible.

Incidentally, if those community colleges with the necessary access to clinical facilities do happen to get involved with the education of nurses and other paramedical personnel (as a result of the Department of Education assuming control of such programs), there is no reason why they cannot also take on the one-year certificate programs in teaching, public health and administration which have been dropped by the universities. Such an action should be undertaken, of course, only in the light of a demonstrated need and place for personnel with this level of training. (The need for this *type* of specialist is great, but the profession is split as to whether the one-year program is really adequate.)

How to improve and facilitate the provision of nursing education. The problem of where nursing school facilities should be located must not be confused with that of who controls them. There is currently considerable debate as to whether diploma schools of nursing should be located within the grounds of community colleges, on the grounds of hospitals, or in a location apart from both of these. Unfortunately this question has become entwined with that regarding where the ultimate authority over these schools should be. The considerations governing the decision on these two issues are quite different. The siting of a school should take account of the following considerations:

- 1) The needs of the region for nurses and for a conveniently located nursing school or training centre.
- 2) The availability of clinical facilities in the area. Some community colleges may not be located in a place where an adequate number and quality of clinical facilities are available at reasonable distance from the school. The same holds for some hospitals — their own clinical resources are limited and the remainder are located a great distance away, necessitating much travel to and fro.
- 3) The availability of staff. Nursing schools located in community colleges can make use of staff and courses in subjects offered to other students. On the other hand, schools located in hospitals near to community colleges and universities can and do arrange to import teachers from these institutions or send their students to these places for certain courses.

- 4) Potential cost savings. Detailed cost breakdowns should be made to ascertain the extent to which the community college or hospital can reduce costs by providing administrative, clerical, accounting, maintenance and dietary services by means of sharing existing facilities and staff. The community colleges, if convenient in other respects, might have an advantage in already possessing residence and laboratory facilities which in the case of schools located in hospitals would have to be newly built.
- 5) It is necessary that the social psychological effects on the students of locating either in hospitals or in community colleges be carefully studied. It is commonly recognized that the educational process involves the shaping of attitudes towards learning, towards one's profession, and towards other groups and institutions with which the profession is connected. Schools located in hospitals have the advantage of building high levels of student cohesiveness (because of grouping the girls in residences in which no other kinds of students are quartered), and a high level of identification with the hospital and with work in hospitals. Professional identity is confined largely to the subgroup in the profession who perform general duty nursing in hospitals. On the other hand, a serious attitude towards the educational process may be discouraged because of the basically service nature of the hospital. Many nurse educators also feel the hospital-based student nurse loses the cultural and intellectual broadening which might accrue from living and studying among students in other courses and programs.

In the case of schools located in community colleges, one might expect cohesiveness and professional identity to be less, depending on how many classes they take together and whether or not the students are in residence together. At the very least, if nursing students were not given an opportunity to develop group spirit and identity through studying and living together, they should be made to feel a part of a larger "health sciences" group within the college made up of students in related occupational programs. The problem of learning to accept and identify with hospital nursing for nursing students in community colleges would depend very much on the attitudes of their teachers on this subject, the length of their clinical experiences in hospitals, and the amount and quality of their relationships with hospital staff. All would have to be watched very carefully or it would indeed be easy for the community college nurse to become disenchanted with or apprehensive of future employment in hospitals. In general, there is considerable need for comprehensive studies of the effects on the attitudes of student nurses, both during and after their education, of siting nursing schools in community colleges as opposed to hospitals.

There is an imperative need for a detailed and expert analysis of the teacher's position in R.N. diploma schools and R.N.A. training centres. If the impending severe shortage of teachers is to be met, it is critical that the teacher's duties and responsibilities be identified in detail and examined from the point of view of dropping some, allocating others to clerical or administrative staff, and identifying those which could be performed by less qualified personnel. An initial attempt to provide teaching assistants failed, largely because a detailed definition of the work such a person could do was not made and tested for feasibility.

At the university level, the basic prerequisite to the enlargement of baccalaureate degree programs is the immediate increase in faculty sizes and increased budgets to permit the reduction of teaching loads, the financing of research, the launching of graduate programs, and the attraction of high calibre senior faculty (all of which are necessary before other faculty will rush to join a school in significant numbers).

Also at the university level, it is important to devise ways and means for increasing the amount of contact between university nursing school faculty and the practitioners in nursing in order to close what some feel to be the great and ever-widening gulf between the two. Investigations should begin into the possibility of using selected highly qualified practitioners as part-time instructors in university nursing courses (as is commonly done in medicine) and, conversely, the creation of time and opportunity for nursing school faculty to function in some type of practitioner role at regular intervals throughout their career (for example, as part-time service administrators in teaching hospitals attached to universities or as consultants to hospitals, public health agencies, or diploma nursing schools and training centres).

Ways to facilitate the increase in enrolments in nursing schools. Nursing educators are desirous of charging fees to students for their education. The effect of such a procedure on enrolments is unknown, since there is no country or large region where *all* nursing schools charge a fee. There is no question that universal free nursing education is very costly. It *might* be possible to reduce this cost by making bursaries available to cover fees and room and board for all those who can show need, and by charging the remainder of the students according to their ability to pay. Unfortunately, it is not possible to test this kind of plan on a small scale in only one or two schools, because those who lack the money for their education will be free to apply to other schools not charging fees. Perhaps the only alternative is the risky one of trying out a province-wide "fees plus bursary" scheme for a year or two. The potential for saving might be worth the risk of incurring a slightly lower enrolment.

There is no question that, at the university level, the existing scheme for bursaries, scholarships and other financial aid needs examination. Diploma-trained R.N.'s returning for a degree can get assistance from the Department of Health

for only two years, while most universities now require three years of study. Also, the Department of Health bursary plan does not extend to regular baccalaureate students. Perhaps it should if the Ontario Student Awards Plan proves on investigation to provide inadequate coverage of student expenses.

There is also a need to increase the selection of opportunities for diploma-trained nurses to obtain degrees by making university studies available in the evenings and during the spring and summer sessions. The "mature student" admission requirements by which many Ontario universities now admit students over a certain age who have not met all the academic entrance requirements should be elaborated in detail for nurses and communicated widely among all practitioners. The university nursing schools have been slow to do this so far.

It is important to standardize and centralize admission procedures and to improve the recruiting programs for students. Both activities would ensure that more potential students apply and that all applications receive consideration by all schools and training centres in the province.

Finally the recommended central authority on nursing education should

- 1) Aggressively publicize the recently introduced maturity clause for diploma school and R.N.A. training centre applicants, so as to forcefully encourage older and well motivated students with adequate aptitudes and abilities to enrol in nursing programs in spite of not meeting formal high school academic admission requirements. It should also investigate in this connection the need for the development of additional nursing schools along the lines of the existing Quo Vadis school to accommodate additional numbers of mature students.
- 2) Immediately begin studies into the feasibility of creating one or more schools primarily for male nurses.
- 3) Undertake research into and development of psychological tests to improve the predictability of success in nurse training programs and practice thereafter. Such tests are not well developed and validated at present; but, if improved, they might substantially reduce the intake of unsuitable students who subsequently form part of the 20 per cent drop-out group now existing in Ontario nurse training programs.

The Final Problem: Research

It is a cliché these days to end a study of almost anything with the conclusion that "more research is necessary". This trite phrase appears automatically because it gives the work a certain scholarly tone, and it implicitly excuses the author for

all his errors of omission and commission (since he can plead that not enough was known). In spite of this, it must be stated that the need for more and better research was never so appropriate a conclusion as when it is applied to the area of nursing education. The specific questions needing this additional study have been identified throughout this summary chapter and those preceding it. The same conclusion has been reached by virtually every published study preceding this one. Everyone deplores the paucity of research, but no one does anything about it. What is needed, then, at the highest levels within government and particularly within the nursing profession itself is a set of detailed programs to provide more money, more and better qualified research staff, and a spirit of ambition and cooperation to get this research done.

Appendix I

Coding system for nursing activity studies conducted by the OHSC.

1. Classification of Activities According to Area.
2. Classification of Activities According to Level.
3. Samples of Coding.

Classification of Activities According to Area

Codes for the *activity areas* as defined for this study are as follows:

Patient Care

<i>Code</i>	<i>Definition</i>
Codes 11 and 12	will be used only when the person being observed is actually with patients.

Direct Patient Care

11 *"Patient: Giving care" includes:*

Assisting doctors with treatments or procedures. (Except when the care is given as a demonstration to teach staff or students; then it will be coded as "In-service development of personnel", or "Student nurse program".)

Carrying out a nursing procedure for a patient. (Except when the care is given as a demonstration to teach staff or students; then it will be coded as "In-service development of personnel", or "Student nurse program".)

12 *"Patient: Other direct activities" means all activities in the patient's presence that are not a part of those classified as "Patient: Giving care". It includes:*

Evaluation of patient's need for care.

Informative conversation or exchange of pleasantries with the patient.

Listening to requests, wishes and complaints of patients and making interpretation.

Observing physical condition and behaviour of patients.

Teaching patients.

All other activities in patient's presence not considered as nursing care.

Indirect Patient Care

13 *"Patient: Exchange of information about patient" includes:*

Exchanging verbal reports about a specific patient or patients with unit personnel, nursing service administration, physicians, other hospital departments, patient's family and friends, and other interested persons or agencies.

- Listening to or giving a.m. or p.m. report.
- Receiving or giving an assignment relating to patient care.
- Discussing an assignment of patient care.
- Telephoning other departments about scheduling patients' appointments.
- Ordering drugs, supplies, or equipment by telephone for a specific patient or patients.
- Reporting on or off duty.

- 14 "*Patient: Indirect care*" means all other patient-centred activities not in the presence of the patient and not involving an exchange of information about a patient. It includes:
- Care of records and record forms relating to patient care.
 - Charting of care given.
 - Checking of doctor's orders.
 - Errands for patients.
 - Preparation of medications and treatment trays.
 - Setting up and terminal care of equipment.

Personnel

- 21 "*Personnel: In-service development of staff*" refers to participation in all activities conducive to improved nursing service and unit management. It includes:
- Conversations with unit personnel, physicians and personnel of other departments, to maintain favourable rapport and good interpersonal relationships.
 - Demonstrations.
 - Giving and receiving an interpretation of hospital policy as it affects the unit staff.
 - Giving or receiving planned or impromptu teaching.
 - Staff meetings attended by personnel.
 - Making personnel records and conferring about personnel matters.
 - Observing and evaluating quality of work.
 - Errands in search of unit personnel.
- 22 "*Personnel: Student nurse program*" includes all activities relating to the student nurse program, such as:
- Planning student education.
 - Discussions about students with unit personnel, nursing service administration, and doctors.
 - Evaluating students.
 - Teaching students.
- (Activities in which students are involved must be weighed carefully in terms of whether they are patient-centred or student-centred. For example, assign-

ment of patient care to a student will generally be coded as 13. Students' rounds with doctors will generally be coded as 22, because this activity is probably more student-centred than patient-centred.)

Code	Definition
Unit Management	
30	This classification includes: Housekeeping, maintenance of cleanliness, order and safety on the unit. Obtaining required supplies and equipment, and all discussions and exchanges of information regarding these activities. Interpreting a hospital policy or procedure to persons other than unit staff or patients. Example: Explaining hospital regulations to visitors. Serving on committees for the purpose of discussing, revising, or formulating hospital and nursing policy and procedure. Activities related to this study. Discussions, compilation of data, and so forth, for any other research studies.

Personal and Unoccupied

- 00 This classification includes:
All activities that are personal, such as conversation about personal affairs, coffee time.
Time when an individual is unoccupied and no unit purpose can be identified.

Classification of Activities According to Level

Codes for the *activity levels* as defined in this study are as follows:

Code	Definition
Hn	Head nurse and assistant head nurse level activities are those that involve:
Ahn	Planning, directing, evaluating, coordinating, reviewing, and making decisions concerning nursing care in the unit. Giving nursing care in emergency situations. Giving nursing care in order to have opportunity to observe patients, to establish rapport with patients, or to teach nursing staff.
Rn	Professional staff level activities are those requiring some professional nursing skill. However, in the case of nursing activities performed <i>in the presence of the patient</i> (areas 11 and 12) no attempt will be made to distinguish between professional and non-professional nursing levels. That is, any nursing procedure a professional nurse performs in the presence of a patient, no matter how elementary it seems, will be classified as Rn level. Likewise, a nursing procedure done by a nursing assistant in the presence of a patient will be

classified on the Na level unless the assistant is doing something she actually does not have permission to do. The same reasoning applies to activities carried out by student nurses.

The reason for not distinguishing nursing *levels* in activities performed *at the patient's bedside* is that unless the nurse is observed continuously it is often difficult to determine the real skill requirements of an activity. With intermittent observations, a professional nurse might be observed straightening a patient's pillow, a simple activity that could be performed by a nursing assistant. However, a moment before this she might have been changing a patient's dressing, and then have straightened the pillow to make the patient comfortable after the dressing procedure.

Activities *away from the patient's bedside*, however, can be classified according to level of nursing skill required. Thus, if the professional nurse is cleaning equipment in the utility room, this task is clearly reassignable to a nursing assistant.

Professional staff level activities *away from the patient* include:

Discussing patient's condition.

Discussing patient's response and recording of response.

Preparing medications or equipment when these responsibilities are not included in job descriptions of the non-professional personnel.

Na *Nursing assistant level* refers to all activities included in the job description of a nursing assistant, if this job exists in the hospital. No attempt will be made to differentiate the levels of nursing activities performed *in the presence of the patient* unless the nursing assistant clearly is doing something not included in a nursing assistant's job description. For example, if a nursing assistant is not permitted to take blood pressure but is observed taking blood pressure, this would be coded Rn level.

Activities away from the patient will be differentiated according to job description.

Or *Orderly level* refers to all activities included in the job descriptions of orderlies, if these jobs exist in the hospital. Nursing activities performed by orderlies *in the presence of the patient* are coded on the orderly level unless the orderly is doing an activity he actually is not permitted to do. For example, he may be observed irrigating a deep wound although this is not included in an orderly's job description; the activity then would be coded Rn level.

Wa *Ward aide level* refers to all activities included in the job description of ward aides if this job exists in the hospital.

Cl *Clerical level* activities include:

Copying records, as nursing time sheets.

Maintaining graphic records.

Assembling chart forms on patient's admission.

Filling in chart heading.

Checking charts on discharge.

Making out requisitions for specimens, laboratory services, x-rays, or other professional services.

Copying, routing, maintaining, and filing records and written communications that are essential in coordinating professional services in a department or between departments.

D *Dietary level activities include:*

Care of unit diet kitchen.

Setting up trays.

Supervising service of food.

Carrying or picking up trays.

Washing trays and dishes.

Preparing and serving nourishment between meals.

Cleaning water glasses and pitchers.

H *Housekeeping and care of equipment level activities (in the unit) include:*

Cleaning floors, windows, bathrooms, and service rooms (except narcotic cabinet).

Emptying wastebaskets, dusting furniture in occupied rooms, general cleaning of head nurse station.

Cleaning room after patient is discharged, including washing and making up bed.

(A nurse may do the initial clean up when a patient spills something, or in caring for patients when she is with them. This is not considered housekeeping level.)

Mes *Messenger level*

Delivering routine requisitions.

Picking up emergency orders of drugs and supplies.

Accompanying patients to other parts of hospital, if this is established hospital policy.

SAMPLES OF CODING

Person		Area	Level
Observed	What was done		
Hn	Removed I.V. (emergency)	11	Hn
Hn	Assisted doctor with treatment	11	Rn
Hn	Passed medications	11	Rn
Hn	Made rounds with doctors	12	Hn
Hn	Asked patient how he felt	12	Hn
Hn	Observed post-operative patient	12	Hn
Hn	Brought patient a glass of water	12	Rn or Na
Hn	Told student nurse to answer patient's light	13	Hn
Hn	Discussed patient's condition with doctor	13	Hn
Hn	Listened to a.m. report	13	Hn
Hn	Called laboratory for patient appointment	13	Cl
Hn	Planning assignments	14	Hn
Hn	Writing p.m. report	14	Hn
Hn	Preparing medications	14	Rn
Hn	Charting patient care	14	Rn
Hn	Filing patient's charts	14	Cl
Hn	Checking diet list with diet orders	14	Cl or D
Hn	Telling aide how to fill out chart	21	Hn
Hn	Discussing orientation program with supervisor	21	Hn
Hn	Writing evaluation reports for staff nurse	21	Hn
Hn	Exchanging pleasantries with doctors	21	Hn
Hn	Planning a vacation schedule	21	Hn
Hn	Explaining to student how to use a respirator	22	Hn
Hn	Discussing a student nurse's work with an instructor	22	Hn
Hn	Making out requisition for drugs for supply closet	30	Cl
Hn	Discussing with staff nurse need for painting a cabinet	30	Hn
Hn	Explaining visiting hours to patient's relatives	30	Hn
Hn	Talking to observer about this study	30	Hn
Hn	Putting linens in linen closet	30	Na
Hn	Cleaning her desk	30	Cl or H
Hn	Filing requisitions	30	Cl

SAMPLES OF CODING

Person Observed	What was done	Area	Level
Hn	Coffee break	00	—
Rn	Took patient's temperature	11	Rn
Rn	Feeding patient	11	Rn
Rn	Took patient to bathroom	11	Rn
Rn	Changed linen — patient in bed	11	Rn
Rn	Brought patient a glass of milk	12	D
Rn	Straightened patient's stand	12	Rn
Rn	Making empty bed — patient in chair	12	Rn
Rn	Answering patient's light	12	Rn
Rn	Conversing with patient	12	Rn
Rn	Taking patient to operating room	12	Rn or Mes
Rn	Bringing patient his mail	12	Rn or Cl
Rn	Reporting on duty	13	Rn
Rn	Telling aide about patient's diagnosis	13	Rn
Rn	Getting an assignment from head nurse	13	Rn
Rn	Ordering drugs for particular patient	13	Cl
Rn	Preparing penicillin	14	Rn
Rn	Checking doctor's orders	14	Rn
Rn	Charting temperature	14	Rn or Cl
Rn	Heading chart for a new patient	14	Cl
Rn	Emptying bedpan	14	Rn or Na
Rn	Making out charge slips	14	Cl
Rn	Attaching x-ray reports to charts	14	Cl
Rn	Cleaning up after catheterization	14	Na
Rn	Checking trays	14	Rn or D
Rn	Taking equipment out of patient's room (terminal)	14	Na
Rn	Attending staff nurses' conference	21	Rn
Rn	Exchanging pleasantries with student nurse	21	Rn
Rn	Showing student nurse how to prepare dressing	22	Rn
Rn	Making discharged patient's bed	30	H
Rn	Washing dishes	30	D
Rn	Folding and storing linen	30	Na
Rn	Sterilizing equipment	30	Na
Rn	To bathroom	00	—

Student nurses' activities are always coded the same as staff nurses' activities except for the *personnel* area where code 22 is always used instead of code 21. Examples:

Stud	Discussing evaluation records with head nurse	22	Rn
Stud	Making rounds with doctors (student education)	22	Rn
Stud	Asked aide to show her where linens are kept	22	Rn
Na	Bathing patient	11	Na
Na	Helped patient into bed	12	Na
Na	Observed patient being catheterized	12	Na
Na	Off unit — took patient to office	12	Na or Mes
Na	Told doctor patient didn't sleep well	13	Na
Na	Calling laboratory about blood specimens	13	Cl
Na	Charting blood pressure	14	Na
Na	Looking for doctor — off the unit	14	Mes
Na	Having annual x-ray taken	21	Na
Na	Reading about dosage for drugs	21	Na
Na	Helping to move bed from one empty room to another	30	H
Na	Checking stock drugs	30	Cl
Na	Making linen packs	30	H or Na
Na	Calling beauty parlor for appointment for herself	00	—

Student nursing assistants' activities are coded the same as activities of nursing assistants except for the *personnel* area where code 22 is always used instead of 21. Examples:

Sna	Watched head nurse set up treatment tray	22	Na
Sna	Asked instructor about work schedule for next week	22	Na
Na	Gave patient back rub	11	Na
Na	Helping patient to light cigarette	12	Na
Na	Closing window for patient	12	Na
Na	Told Rn patient refused to eat	13	Na

Na	Filling hot water bottle for patient	14	Na
Na	Getting equipment for patient	14	Na
Na	Making out leave slip	21	Na
Na	Sterilizing glasses	30	Na
Na	Waxing floors in hallway	30	H
Na	Cleaning kitchen	30	D
Na	Resting	00	—
Cl	Giving patient a package	12	Cl
Cl	Looking for doctor's phone number to call him about patient	13	Cl
Cl	Showing visitor to patient's room	13	Cl
Cl	Ordering drug for patient	13	Cl
Cl	Making requisition for x-ray films	14	Cl
Cl	Making chart for new patient	14	Cl
Cl	Transcribing doctor's order to Kardex	14	Cl
Cl	Typing time sheets	21	Cl
Cl	Straightening out bulletin board	21	Cl
Cl	Filing student evaluation forms	22	Cl
Cl	Telephoning re: religious sermons	30	Cl
Cl	Calling about cracked window pane	30	Cl
Cl	Telling patient's relatives how to go to business office	30	Cl
Cl	Making out requisition for stock drugs	30	Cl
Cl	Putting away supplies	30	Cl or Na
Cl	Visiting friend on other floor	00	—
H	Washing floor in patient's room — patient in bed	12	H
H	Folding linens	30	H or Na
Dm	Picking up trays	30	D
Dm	Washing dishes	30	D
Mes	Taking specimens to laboratory	30	Mes

NOTE: Terminology of the various categories of personnel used in the study should be compatible with that in use in the hospital being studied.

Appendix II

Studies of overall nursing supply and demand in hospitals (in 1964, '65, and '66), measured by the "hours of care per day" method.

(Prepared for internal use by the OHSC)

Nursing Personnel Study 1964, 1965

1. Paid hours of work upon which these tables were based were obtained from page 12 of the 1964 and 1965 Annual Return of Hospitals Part I, Facilities and Services, Form HS-1.
2. Hours of care per diem were based on total adults and children days of care plus $\frac{1}{4}$ newborn days of care.
3. Included are hours of the nursing education staff.
4. Excluded are the service and educational hours of student nurses and trainee nursing assistants.
5. Applicable definitions of nursing department staff as provided in the 1964 and 1965 Handbook of Instructions and Definitions for the Annual Return of Hospitals Part I, Facilities and Services, Form HS-1 are as follows:

Graduate nurses — Persons who have graduated from a school of nursing approved by the legally appointed body in the province and qualified to take examination for registered nurse.

Graduate nurses — nursing directors — Includes persons trained to the level of graduate nurse who are directors, associate directors and assistant directors of nursing services and nursing education.

Graduate nurses — nursing supervisors — Includes persons trained to the level of graduate nurse responsible for the supervision of two or more nursing units or one or more special units within the nursing department such as obstetrical units, operating room suite, etc., or evening or night supervision of the nursing service as a whole.

Graduate nurses — head nurses — Includes persons trained to the level of graduate nurse and responsible for the nursing care of patients, ward administration and supervision of nursing staff in one nursing unit of the hospital.

Graduate nurses — assistant head nurses — Includes persons trained to the level of graduate nurse and responsible for assisting the head nurse in the administration and supervision of a nursing unit.

Graduate nurses — teaching — Includes all professional nursing personnel trained to the level of graduate nurse and whose responsibility is the training of graduate nurses, student nurses or auxiliary nursing personnel. Include clinical instructors under this heading.

Graduate nurses — general duty — Refers to professional nursing personnel trained to the graduate level and carrying out regular bedside nursing duties on the wards of the hospital.

Graduate nurses — other — Refers to professional nursing personnel trained to the graduate level and assigned to special nursing services of the hospital. This includes nurses assigned to the plaster room, dressing room, operating room, emergency unit, delivery room, outpatient department, etc., excluding supervisory categories of personnel.

Qualified nursing assistants — Persons who have completed a formal course of training below the level of a graduate nurse. This term includes certified nursing assistants and certified nursing aides, licensed or certified practical nurses, psychiatric nurses, maternity nurses, operating room technicians, and persons of similar status, whose course has not qualified them to take examination for registered nurse.

Orderlies — Include orderlies and student orderlies employed by the hospital.

Other nursing department personnel — All other nursing department personnel not entered elsewhere, including ward clerks, secretarial staff, ward aides, and "garde-bébés".

This study was initiated at the request of Miss G. J. Sharpe, Senior Consultant, Nursing Services, Hospital Standards Division. The objective of the study is to provide, in hospital bed number groupings, comparative data on the composition and extent of nursing services provided per patient day for the two years under study.

Table A1

This table presents a comparison of paid hours of work within the nursing department for the years 1964 and 1965. The public hospitals in the Province of Ontario, groups A to G, show an absolute increase of .2 paid hours of care per diem while the percentage of hours of work of graduate nurses to the total hours of work of the nursing department increased by .9. The per cent of care given by graduate nurses has increased in all of the bed number groupings, with the exception of the large group A hospitals, 900 beds and over, and the group E convalescent hospitals.

The decrease in per cent of care given by graduate nurses in the large group A hospitals is entirely offset by the care given by qualified nursing assistants.

The decrease in the group E convalescent hospitals was accompanied by a

decrease in the hours of qualified nursing assistants and orderlies. These decreases totalling 2.6 were offset by an increase of 2.6 in other nursing department personnel. The per cent of care given by orderlies and other nursing department personnel shows a downward trend in the majority of the bed number groupings.

Table A2

In Table A1 the graduate nurse hours are shown as a percentage of the total nursing department hours. Table A2 shows a distribution of that percentage into the various job categories.

The percentage decrease in graduate nurse hours in the large group A hospitals, 900 beds and over, totalling 2.3 resulted from a .4 decrease in the hours of head nurses and assistant head nurses and a 1.9 decrease in general duty and other nurses. Of this decrease .4 was offset by minor increases in directors, supervisors and instructors.

In the group E convalescent hospitals 50 per cent of the decrease was at the general duty level.

All other hospital bed number groupings show an increase from .2 to 3.8 (exclusive of group D hospitals) for graduate nurses.

The percentage of hours worked by directors and supervisors, shown as a decrease from 1965/1964, is not due to a decrease in actual positions — see Table A4 — but rather, to a different percentage distribution due to the overall expansion of nursing services provided.

Tables A3 and A4

These tables provide a comparison of full-time equivalent nursing department personnel by classification for the years 1964 and 1965.

For the purpose of calculating the number of full-time equivalent personnel, 2,080 hours of work per employee was adopted as a uniform base.

It is recognized that some hospital personnel actually work less than a forty-hour week, but it was felt to be too time consuming to make the necessary adjustments.

Table A5

This table provides a recapitulation of full-time equivalent nursing department personnel for the years 1963 to 1965 and projections for the years 1966 and 1967, as well as percentage increases or decreases for the years 1964/1963 and 1965/1964. The data in this table show a continued increase in total nursing department personnel during the period 1963 to 1965. This of course would be expected since there was an increase of 1,574 beds from 1963 to 1964 and 613

beds from 1964 to 1965 in public hospitals in the Province of Ontario. While the increase of full-time equivalent personnel is at a diminishing rate, it is still substantial, especially at the graduate nurse — general duty and other — levels.

There is an increase of 4.7 per cent in the total full-time equivalent nursing department personnel 1965/1964 and an increase of 6.7 per cent in the graduate nurses, which would tend to indicate that the anticipated shortage of graduate nurses for the future is not yet apparent, especially since there is an absolute increase of .2 paid hours of care per diem 1965/1964 — see Table A1 and the table shown below.

The following table summarizes the expansion of nursing services in public hospitals, groups A to G in the Province of Ontario between the years 1963 and 1965.

	Total Adult and Child Plus $\frac{1}{4}$ Newborn Days of Care	% Increase or (Decrease)	Hours of Care Per Diem	Full-time Equivalent Nursing Dept. Personnel
1963	11,916,632		5.7	32,685.1
1964	12,421,813		5.8	34,864.9
Increase 1964/1963	505,181	4.2	.1	2,179.8
1965	12,735,982		6.0	36,500.4
Increase 1965/1964	314,169	2.5	.2	1,635.5

The table below summarizes the expansion of nursing services in public general hospitals including convalescent and chronic units, groups A to C, (Red Cross Outposts — group D — are excluded) between the years 1963 and 1965.

	Total Adult and Child Plus $\frac{1}{4}$ Newborn Days of Care	% Increase or (Decrease)	Hours of Care Per Diem	Full-time Equivalent Nursing Dept. Personnel
1963	10,397,091		6.0	29,870.4
1964	10,812,381		6.1	31,809.6
Increase 1964/1963	415,290	4.0	.1	1,939.2
1965	11,041,188		6.3	33,219.7
Increase 1965/1964	228,807	2.1	.2	1,410.1

TABLE A1**Comparison of Nursing Department Hours of Work for the Years 1964 and 1965**

(Includes hours of Nursing Education Staff but excludes Service and Educational hours of Students and Trainee Nursing Assistants)

Hospitals By Number of Beds	Hours of Care Per Diem ²			Hours of Graduate Nurses as a % of Total Hours		
	1964	1965	Increase (Decrease)	1964	1965	Increase (Decrease)
GENERAL HOSPITALS						
GROUP A						
900 +	6.2	6.5	.3	48.4	46.5	(1.9)
500-899	6.3	6.4	.1	55.9	56.1	.2
200-499	6.2	6.3	.1	60.0	61.6	1.6
Other Group A Hospitals ¹	8.4	8.5	.1	53.3	56.7	3.4
Total Group A Hospitals	6.4	6.6	.2	53.2	52.9	(.3)
GROUPS B AND C						
400 +	5.7	5.9	.2	53.8	54.0	.2
350-399	5.9	6.1	.2	48.6	50.8	2.2
300-349	6.2	6.3	.1	52.4	56.2	3.8
250-299	6.2	6.3	.1	52.9	53.6	.7
200-249	6.3	6.3	—	53.7	54.6	.9
150-199	6.1	6.1	—	51.1	53.2	2.1
100-149	6.1	6.2	.1	52.9	53.9	1.0
Total Groups B and C—100 +	6.1	6.2	.1	52.3	54.0	1.7
GROUPS B AND C						
50-99	5.8	5.9	.1	50.3	51.2	.9
1-49	5.3	5.4	.1	51.6	53.4	1.8
Total Groups B and C—1-99	5.6	5.7	.1	50.7	51.8	1.1
GROUP D						
4-22	5.4	5.7	.3	60.5	67.7	7.2
Total Groups A to D	6.1	6.3	.2	52.4	53.4	1.0
CONVALESCENT HOSPITALS						
Group E	3.9	3.9	—	37.6	36.6	(1.0)
HOSPITALS FOR THE CHRONICALLY ILL						
Groups F and G	3.9	4.0	.1	23.9	25.8	1.9
GRAND TOTAL—						
GROUPS A TO G	5.8	6.0	.2	50.3	51.2	.9

¹Other Group A Hospitals are the Hospital for Sick Children and the Princess Margaret Hospital.²Hours of care per diem were based on total adult and child days of care plus $\frac{1}{4}$ newborn days of care.

Hours of Qualified Nursing Assistants as a % of Total Hours			Hours of Orderlies as a % of Total Hours			Hours of Other Nursing Department Personnel as a % of Total Hours		
1964	1965	Increase (Decrease)	1964	1965	Increase (Decrease)	1964	1965	Increase (Decrease)
14.9	16.8	1.9	11.3	10.8	(.5)	25.4	25.9	.5
11.7	10.2	(1.5)	9.5	9.2	(.3)	22.9	24.5	1.6
12.3	12.4	.1	5.8	5.5	(.3)	21.9	20.5	(1.4)
14.4	15.7	1.3	.9	.9	—	31.4	26.7	(4.7)
13.3	13.5	.2	9.0	8.7	(.3)	24.5	24.9	.4
13.8	12.8	(1.0)	6.9	6.9	—	25.5	26.3	.8
16.3	17.0	.7	7.0	6.9	(.1)	28.1	25.3	(2.8)
21.4	22.2	.8	4.9	4.6	(.3)	21.3	17.0	(4.3)
13.7	15.5	1.8	4.3	4.7	.4	29.1	26.2	(2.9)
18.1	18.8	.7	5.8	5.6	(.2)	22.4	21.0	(1.4)
21.7	20.1	(1.6)	5.5	5.3	(.2)	21.7	21.4	(.3)
24.5	25.2	.7	4.4	4.0	(.4)	18.2	16.9	(1.3)
18.5	18.7	.2	5.6	5.4	(.2)	23.6	21.9	(1.7)
25.8	26.0	.2	4.6	4.4	(.2)	19.3	18.4	(.9)
21.1	22.1	1.0	3.0	2.9	(.1)	24.3	21.6	(2.7)
24.5	25.0	.5	4.2	4.0	(.2)	20.6	19.2	(1.4)
29.7	29.1	(.6)	2.2	3.2	1.0	7.6	—	(7.6)
17.4	17.6	.2	6.6	6.4	(.2)	23.6	22.6	(1.0)
19.7	18.5	(1.2)	13.7	13.3	(.4)	29.0	31.6	2.6
15.2	14.7	(.5)	10.4	9.8	(.6)	50.5	49.7	(.8)
17.3	17.5	.2	7.0	6.8	(.2)	25.4	24.5	(.9)

TABLE A2

Comparison of Nursing Department Hours of Care Per Diem and Distribution of Graduate Nurse Hours of Work, 1964 and 1965

(Includes hours of Nursing Education Staff but excludes Service and Educational hours of Students and Trainee Nursing Assistants)

Hospitals By Number of Beds	Hours of Care Per Diem ²			Hours of Directors, Assoc. Directors and Asst. Directors as a % of Total Hours			Hours of Supervisors as a % of Total Hours		
	1964	1965	Increase (Decrease)	1964	1965	Increase (Decrease)	1964	1965	Increase (Decrease)
GENERAL HOSPITALS									
GROUP A									
900 +	6.2	6.5	.3	.5	.6	.1	3.0	3.1	.1
500-899	6.3	6.4	.1	.6	.6	—	2.8	2.6	(.2)
200-499	6.2	6.3	.1	1.1	1.4	.3	3.3	2.9	(.4)
Other Group A Hospitals ¹	8.4	8.5	.1	1.1	1.2	.1	3.8	3.6	(.2)
Total Group A Hospitals	6.4	6.6	.2	.7	.7	—	3.0	2.9	(.1)
GROUPS B AND C									
400 +	5.7	5.9	.2	1.1	1.0	(.1)	3.0	2.7	(.3)
350-399	5.9	6.1	.2	.9	.8	(.1)	3.9	4.3	.4
300-349	6.2	6.3	.1	.9	.7	(.2)	2.9	3.0	.1
250-299	6.2	6.3	.1	1.1	.9	(.2)	3.8	3.4	(.4)
200-249	6.3	6.3	—	1.3	1.3	—	3.8	3.6	(.2)
150-199	6.1	6.1	—	1.6	1.7	.1	3.9	4.3	.4
100-149	6.1	6.2	.1	1.3	1.3	—	6.3	5.5	(.8)
Total Groups B and C—100+	6.1	6.2	.1	1.2	1.1	(.1)	3.8	3.7	(.1)
GROUPS B AND C									
50-99	5.8	5.9	.1	2.0	1.9	(.1)	6.6	6.5	(.1)
1-49	5.3	5.4	.1	2.1	2.5	.4	6.2	6.1	(.1)
Total Groups B and C—1-99	5.6	5.7	.1	2.0	2.1	.1	6.5	6.4	(.1)
GROUP D									
4-22	5.4	5.7	.3	—	—	—	—	—	—
Total Groups A to D	6.1	6.3	.2	1.1	1.1	—	3.8	3.7	(.1)
CONVALESCENT HOSPITALS									
Group E	3.9	3.9	—	1.3	1.1	(.2)	4.1	3.9	(.2)
HOSPITALS FOR THE CHRONICALLY ILL									
Groups F and G	3.9	4.0	.1	1.1	1.1	—	2.8	2.9	.1
GRAND TOTAL—GROUPS A TO G									
	5.8	6.0	.2	1.1	1.1	—	3.7	3.6	(.1)

¹Other Group A Hospitals are the Hospital for Sick Children and the Princess Margaret Hospital.

²Hours of care per diem were based on total adult and child days of care plus $\frac{1}{4}$ newborn days of care.

Hours of Head Nurses, Asst. Head Nurses as a % of Total Hours			Hours of Instructors as a % of Total Hours			Hours of General Duty and Other Graduate Nurses as a % of Total Hours			Total Hours of Graduate Nurses as a % of Total Nursing Department Hours		
1964	1965	Increase (Decrease)	1964	1965	Increase (Decrease)	1964	1965	Increase (Decrease)	1964	1965	Increase (Decrease)
8.3	7.9	(.1)	2.3	2.5	.2	34.3	32.4	(1.9)	48.4	46.5	(1.9)
7.0	6.7	(.3)	3.1	2.9	(.2)	42.4	43.3	.9	55.9	56.1	.2
9.2	9.3	.1	2.9	3.0	.1	43.5	45.0	1.5	60.0	61.6	1.6
8.0	8.0	—	2.7	2.7	—	37.7	41.2	3.5	53.3	56.7	3.4
7.9	7.6	(.3)	2.7	2.7	—	38.9	39.0	.1	53.2	52.9	(.3)
7.4	7.5	.1	3.0	3.2	.2	39.3	39.6	.3	53.8	54.0	.2
6.2	6.5	.3	2.3	2.6	.3	35.3	36.6	1.3	48.6	50.8	2.2
7.4	8.0	.6	1.6	1.5	(.1)	39.6	43.0	3.4	52.4	56.2	3.8
7.4	7.4	—	2.4	2.3	(.1)	38.2	39.6	1.4	52.9	53.6	.7
6.7	6.9	.2	2.3	2.9	.6	39.6	39.9	.3	53.7	54.6	.9
8.1	7.6	(.5)	2.8	3.2	.4	34.7	36.4	1.7	51.1	53.2	2.1
8.1	8.6	.5	.8	.7	(.1)	36.4	37.8	1.4	52.9	53.9	1.0
7.3	7.5	.2	2.2	2.4	.2	37.8	39.3	1.5	52.3	54.0	1.7
7.0	7.6	.6	.2	.3	.1	34.5	34.9	.4	50.3	51.2	.9
6.3	6.5	.2	—	—	—	37.0	38.3	1.3	51.6	53.4	1.8
6.8	7.3	.5	.2	.2	—	35.2	35.8	.6	50.7	51.8	1.1
14.8	8.6	(6.2)	—	—	—	45.7	59.1	13.4	60.5	67.7	7.2
7.5	7.5	—	2.1	2.2	.1	37.9	38.9	1.0	52.4	53.4	1.0
4.5	4.4	(.1)	.1	.1	—	27.6	27.1	(.5)	37.6	36.6	(1.0)
6.7	6.9	.2	.5	.4	(.1)	12.3	14.5	1.7	23.9	25.8	1.9
7.4	7.4	—	2.0	2.1	.1	36.1	37.0	.9	50.3	51.2	.9

TABLE A3
Comparison of Full-time Equivalent Nursing Department Personnel by
Classification for the Years 1964 and 1965

Hospitals by Number of Beds	Graduate Nurses			Qualified Nursing Assistants		
	F.T. Equiv. 1964	F.T. Equiv. 1965	Increase or (Decrease)	F.T. Equiv. 1964	F.T. Equiv. 1965	Increase or (Decrease)
GENERAL HOSPITALS						
GROUP A						
900 +	2168.1	2198.7	30.6	668.3	791.9	123.6
500-899	2586.6	2708.0	121.4	543.5	491.9	(51.6)
200-499	700.4	743.1	42.7	143.0	149.9	6.9
Other Group A Hospitals ¹	536.8	623.6	86.8	145.0	172.9	27.9
Total Group A Hospitals	5991.8	6273.4	281.6	1499.8	1606.7	106.9
GROUPS B AND C						
400 +	1468.7	1534.1	65.4	377.7	362.1	(15.6)
350-399	1059.5	1172.4	112.9	354.0	393.2	39.2
300-349	1581.7	1888.1	306.4	648.1	745.2	97.1
250-299	1011.3	1211.5	200.2	262.4	351.5	89.1
200-249	1561.4	1517.0	(44.4)	525.2	521.7	(3.5)
150-199	1132.0	1053.4	(78.6)	480.5	399.3	(81.2)
100-149	1010.0	1126.5	116.5	469.4	525.6	56.2
Total Groups B and C—100 +	8824.6	9502.8	678.2	3117.2	3298.6	181.4
GROUPS B AND C						
50-99	1352.4	1420.0	67.6	694.0	721.1	27.1
1-49	498.2	521.9	23.7	203.4	215.8	12.4
Total Groups B and C—1-99	1850.6	1941.9	91.3	897.4	936.9	39.5
GROUP D						
4-22	59.8	69.8	10.0	29.4	30.0	.6
TOTAL Groups A to D	16726.7	17787.9	1061.2	5543.8	5872.3	328.5
CONVALESCENT HOSPITALS						
Group E	285.6	329.2	43.6	150.2	166.4	16.2
HOSPITALS FOR THE CHRONICALLY ILL						
Groups F and G	523.8	587.8	64.0	334.7	335.8	1.1
GRAND TOTAL—						
GROUPS A TO G	17536.1	18704.9	1168.8	6028.8	6374.5	345.7

¹Other Group A Hospitals are the Hospital for Sick Children and the Princess Margaret Hospital.

Totals have been calculated based on the actual paid hours of work and have been rounded to add across but not to add down.

F.T. Equiv. 1964	Orderlies F.T. Equiv. 1965	Increase or (Decrease)	Other Nursing Department Personnel			Total Nursing Department Personnel		
			F.T. Equiv. 1964	F.T. Equiv. 1965	Increase or (Decrease)	F.T. Equiv. 1964	F.T. Equiv. 1965	Increase or (Decrease)
505.0	511.7	6.7	1134.8	1223.2	88.4	4476.2	4725.5	249.3
437.2	441.5	4.3	1058.0	1184.2	126.2	4625.3	4825.6	200.3
67.8	65.9	(1.9)	255.9	247.2	(8.7)	1167.1	1206.1	39.0
9.1	9.7	.6	315.9	294.4	(21.5)	1006.8	1100.6	93.8
1019.1	1028.8	9.7	2764.6	2949.0	184.4	11275.3	11857.9	582.6
189.8	195.4	5.6	697.3	748.3	51.0	2733.5	2839.9	106.4
152.5	158.1	5.6	613.3	583.5	(29.8)	2179.3	2307.2	127.9
147.9	154.3	6.4	643.2	572.6	(70.6)	3020.9	3360.2	339.3
82.7	105.7	23.0	556.1	591.3	35.2	1912.5	2260.0	347.5
168.2	155.1	(13.1)	650.4	581.5	(68.9)	2905.2	2775.3	(129.9)
122.6	104.6	(18.0)	481.9	424.2	(57.7)	2217.0	1981.5	(235.5)
83.3	83.7	.4	348.1	353.1	5.0	1910.8	2088.9	178.1
946.9	957.0	10.1	3990.4	3854.5	(135.9)	16879.1	17612.9	733.8
124.1	121.5	(2.6)	518.9	509.0	(9.9)	2689.4	2771.6	82.2
28.8	28.3	(.5)	235.3	211.3	(24.0)	965.7	977.3	11.6
153.0	149.8	(3.2)	754.1	720.3	(33.8)	3655.1	3748.9	93.8
2.2	3.3	1.1	7.5	—	(7.5)	98.9	103.1	4.2
2121.2	2138.8	17.6	7516.7	7523.7	7.0	31908.4	33322.7	1414.3
104.4	119.9	15.5	220.4	284.2	63.8	760.6	899.7	139.1
228.9	222.5	(6.4)	1108.4	1131.8	23.4	2195.8	2277.9	82.1
2454.4	2481.2	26.8	8845.6	8939.8	94.2	34864.9	36500.4	1635.5

TABLE A4

**Comparison of Full-time Equivalent Nursing Department Personnel by
Classification for the Years 1964 and 1965**

Hospitals By Number of Beds	Directors, Associate Directors and Assistant Directors			Supervisors		
	F.T. Equiv. 1964	F.T. Equiv. 1965	Increase or (Decrease)	F.T. Equiv. 1964	F.T. Equiv. 1965	Increase or (Decrease)
GENERAL HOSPITALS						
GROUP A						
900 +	23.3	28.9	5.6	132.2	146.6	14.4
500-899	28.1	28.7	.6	127.0	124.3	(2.7)
200-499	13.2	16.6	3.4	38.4	34.7	(3.7)
Other Group A Hospitals ¹	11.5	12.9	1.4	38.3	39.7	1.4
Total Group A Hospitals	76.2	87.1	10.9	335.9	345.3	9.4
GROUPS B AND C						
400 +	29.5	27.8	(1.7)	81.4	77.4	(4.0)
350-399	19.9	19.0	(.9)	85.8	98.3	12.5
300-349	26.5	22.4	(4.1)	87.6	99.4	11.8
250-299	20.7	20.4	(.3)	73.5	76.6	3.1
200-249	36.1	36.2	.1	111.3	99.9	(11.4)
150-199	34.8	33.9	(.9)	86.5	84.7	(1.8)
100-149	24.5	28.1	3.6	119.8	115.4	(4.4)
Total Groups B and C—100 +	191.9	187.7	(4.2)	645.9	651.7	5.8
GROUPS B AND C						
50-99	54.5	54.0	(.5)	175.5	179.3	3.8
1-49	19.8	24.2	4.4	60.5	60.0	(.5)
Total Groups B and C—1-99	74.3	78.2	3.9	236.0	239.3	3.3
GROUP D						
4-22	—	—	—	—	—	—
Total Groups A to D	342.4	353.1	10.7	1,217.8	1,236.2	18.4
CONVALESCENT HOSPITALS						
Group E	10.0	10.0	—	31.1	35.0	3.9
HOSPITALS FOR THE CHRONICALLY ILL						
Groups F and G	23.7	24.1	.4	62.4	66.6	4.2
GRAND TOTAL—GROUPS A TO G	376.1	387.2	11.1	1,311.2	1,337.9	26.7

¹Other Group A Hospitals are the Hospital for Sick Children and the Princess Margaret Hospital.

Totals have been calculated on the actual paid hours of work and have been rounded to add across but not to add down.

Head Nurses and Assistant Head Nurses			Instructors			General Duty and Other Graduate Nurses			TOTAL GRADUATE NURSES		
F.T. Equiv. 1964	F.T. Equiv. 1965	Increase or (Decrease)	F.T. Equiv. 1964	F.T. Equiv. 1965	Increase or (Decrease)	F.T. Equiv. 1964	F.T. Equiv. 1965	Increase or (Decrease)	F.T. Equiv. 1964	F.T. Equiv. 1965	Increase or (Decrease)
373.4	373.4	—	102.3	116.3	14.0	1,536.9	1,533.5	(3.4)	2,168.1	2,198.7	30.6
324.7	323.7	(1.0)	144.1	138.3	(5.8)	1,962.7	2,093.0	130.3	2,586.6	2,708.0	121.4
107.7	112.5	4.8	33.7	35.8	2.1	507.4	543.5	36.1	700.4	743.1	42.7
79.9	87.8	7.9	27.6	29.4	1.8	379.5	453.8	74.3	536.8	623.6	86.8
885.6	897.3	11.7	307.7	319.8	12.1	4,386.4	4,623.9	237.5	5,991.8	6,273.4	281.6
202.4	211.6	9.2	81.7	91.9	10.2	1,073.7	1,125.4	51.7	1,468.7	1,534.1	65.4
135.4	150.9	15.5	49.3	59.6	10.3	769.1	844.6	75.5	1,059.5	1,172.4	112.9
222.3	269.1	46.8	48.7	52.0	3.3	1,196.6	1,445.2	248.6	1,581.7	1,888.1	306.4
141.9	167.0	25.1	45.2	52.1	6.9	730.0	895.4	165.4	1,011.3	1,211.5	200.2
195.2	192.8	(2.4)	67.7	79.7	12.0	1,151.1	1,108.4	(42.7)	1,561.4	1,517.0	(44.4)
179.0	150.1	(28.9)	62.9	64.3	1.4	768.8	720.4	(48.4)	1,132.0	1,053.4	(78.6)
155.0	179.9	24.9	16.0	13.7	(2.3)	694.7	789.4	94.7	1,010.0	1,126.5	116.5
1,231.2	1,321.3	90.1	371.5	413.4	41.9	6,384.1	6,928.7	544.6	8,824.6	9,502.8	678.2
188.3	209.3	21.0	6.0	8.3	2.3	928.1	969.1	41.0	1,352.4	1,420.0	67.6
61.0	64.0	3.0	—	—	—	356.9	373.7	16.8	498.2	521.9	23.7
249.3	273.3	24.0	6.0	8.3	2.3	1,285.0	1,342.8	57.8	1,850.6	1,941.9	91.3
14.6	8.9	(5.7)	—	—	—	45.2	60.9	15.7	59.8	69.8	10.0
2,380.0	2,500.8	120.0	685.1	741.5	56.4	12,100.6	12,956.3	855.7	16,726.7	17,787.9	1,061.2
33.8	39.8	6.0	1.0	1.0	—	209.7	243.4	33.7	285.6	329.2	43.6
147.2	157.1	9.9	10.3	9.3	(1.0)	280.2	330.7	50.5	523.6	587.8	64.0
2,561.9	2,697.6	135.7	696.4	751.8	55.4	12,590.5	13,530.4	939.9	17,536.1	18,704.9	1,168.8

TABLE A5

**Full-time Equivalent Staff by Classification for Years 1963 to 1965 and
Projected for Years 1966 and 1967
Also Percentage Increases or Decreases for Years 1964/1963 and 1965/1964**

Public Active, Chronic and Convalescent Hospitals

Based on 1963, 1964 and 1965 Annual Return of Hospitals Form HS-1

Classification of Nursing Department Staff	1963		1964		% Increase or (Decrease) 1964/1963
	Full-time Equivalent	% of Total	Full-time Equivalent	% of Total	
Directors, Associate Directors and Assistant Directors of Nursing Services and Nursing Education	377.6	1.2	376.1	1.1	(.4)
Nursing Supervisors	1,186.9	3.6	1,311.2	3.7	10.5
Head Nurses	1,541.7	4.7	1,625.2	4.7	5.4
Assistant Head Nurses	887.9	2.7	936.7	2.7	5.5
Instructors	684.6	2.1	696.4	2.0	1.7
Graduate Nurses—General Duty (Nursing Units)	9,656.9	29.6	10,136.0	29.1	5.0
Graduate Nurses — Other (Special Nursing Services—Plaster Room, Dressing Room, O.R., Emergency Unit, Delivery Room, O.P.D., etc.)	2,044.5	6.3	2,454.5	7.0	20.1
TOTAL GRADUATE NURSES	16,380.1	50.2	17,536.1	50.3	7.1
Qualified Nursing Assistants	5,440.0	16.6	6,028.8	17.3	10.8
Orderlies	2,291.8	7.0	2,454.4	7.0	7.1
Other Nursing Department Personnel	8,573.2	26.2	8,845.6	25.4	3.2
GRAND TOTAL	32,685.1	100.0	34,864.9	100.0	6.7
% Increase 1964/1963			6.7		
% Increase 1965/1964					
Projected % Increase 1966/1965					
Projected % Increase 1967/1966					

1965 Full-time Equivalent	% of Total	% Increase or (Decrease) 1965/1964	1966		1967	
			Projected % of Total	Projected Full-time Equivalent	Projected % of Total	Projected Full-time Equivalent
387.2	1.1	3.0	1.2	469.6	1.2	510.9
1,337.9	3.6	2.0	4.0	1,565.4	3.9	1,660.4
1,723.7	4.7	6.1	4.7	1,839.4	4.6	1,958.5
973.9	2.7	4.0	2.7	1,056.6	2.8	1,192.1
751.8	2.1	8.0	2.1	821.8	2.2	936.7
10,816.9	29.6	6.7	36.7	14,362.5	37.0	15,752.8
2,713.5	7.4	10.6				
18,704.9	51.2	6.7	51.4	20,115.3	51.7	22,011.4
6,374.5	17.5	5.7	18.7	7,318.2	20.0	8,515.0
2,481.2	6.8	1.1	7.0	2,739.5	7.0	2,980.3
8,939.8	24.5	1.1	22.9	8,961.9	21.3	9,068.5
36,500.4	100.0	4.7	100.0	39,134.9	100.0	42,575.2
4.7				7.2		8.8

Nursing Personnel Study — 1966, 1967

Table A6

As in the previous study, the increase in paid hours of work within the nursing department in public hospitals in the Province of Ontario, groups A to G, shows an absolute increase of .2 paid hours of care per diem while the percentage of hours of work of graduate nurses to the total hours of work of the nursing department increased by 1.0.

None of the bed number groupings shows a decrease in the per cent of care given by graduate nurses except B and C hospitals in the 100-199 group and the Red Cross Hospitals. Any decrease in the 100-149 group B and C hospitals is principally offset by the increase in care given by other nursing department personnel while in the 150-199 group the decrease is offset entirely by the care given by qualified nursing assistants.

In almost all bed number groupings the downward trend continues in the per cent of care given by orderlies and other nursing department personnel.

Table A7

This table shows a distribution of the percentage of graduate nurse hours to total nursing department hours shown in Table A6 into various job categories.

A decrease of .9 per cent in graduate nurse hours in group B and C hospitals of 100-199 beds resulted from a .6 per cent decrease in the hours of supervisors and a 1.4 per cent decrease in general duty and other nurses. The latter decrease was offset by an increase of 1.1 per cent in directors, head nurses, assistant head nurses and instructors.

In Red Cross Hospitals the decrease in graduate nurse hours totalling 4.7 per cent resulted from a decrease of 8.0 per cent in general duty and other nurses being offset by an increase of 3.3 per cent in the hours of head nurses and assistant head nurses.

The percentage of hours worked by directors and supervisors, shown as a decrease in 1966/1965, is not due to a decrease in actual positions (see Table A9) but to a change in percentage distribution due to the overall expansion of nursing services provided.

Tables A8 and A9

These tables provide a comparison of full-time equivalent nursing department personnel by classification for the years 1965 and 1966. Although some hospitals work less than a forty-hour week, 2,080 hours of work per employee was used for the sake of uniformity in calculating the number of full-time equivalent personnel.

Any decrease in full-time equivalent graduate nurses occurred in hospitals with fewer than 250 beds, the greatest decrease being in the 150-199 group which shows a drop of 77.2 per cent. The 150-199 group had a net loss of one hospital in 1966 which largely accounts for the sizable decrease in full-time equivalent graduate nurses within that group. For the total of hospitals in groups A to G there was an increase of 34.7 per cent.

Table A10

This table provides a recapitulation of full-time equivalent nursing department personnel shown in Tables A8 and A9. The per cent increase or decrease for the years 1965/1964 and 1966/1965 is shown and projections for the years 1967 and 1968 are made.

It is interesting to note that graduate nurses are continuing to increase at a faster rate than the total for full-time equivalent nursing department personnel and that by 1968 they are expected to represent 54.6 per cent of the total nursing department.

The following table summarizes the expansion of nursing services in public hospitals, groups A to G, in the Province of Ontario between the years 1964 and 1966.

	Total Adult and Child Plus $\frac{1}{4}$ Newborn Days of Care	% Increase or (Decrease)	Hours of Care Per Diem	Full-time Equivalent Nursing Dept. Personnel
1964	12,421,813		5.8	34,864.9
1965	12,735,982		6.0	36,500.4
Increase 1965/1964	314,169	2.5	.2	1,635.5
1966	13,039,533		6.2	38,628.7
Increase 1966/1965	303,551	2.4	.2	2,128.3

The table below summarizes the expansion of nursing services in public general hospitals including convalescent and chronic units, groups A to C, (Red Cross Outposts — group D — are excluded) between the years 1964 and 1966.

	Total Adult and Child Plus $\frac{1}{4}$ Newborn Days of Care	% Increase or (Decrease)	Hours of Care Per Diem	Full-time Equivalent Nursing Dept. Personnel
1964	10,812,381		6.1	31,809.6
1965	11,041,188		6.3	33,219.7
Increase 1965/1964	228,807	2.1	.2	1,410.1
1966	11,314,093		6.5	35,141.6
Increase 1966/1965	272,905	2.5	.2	1,921.9

Although more nurses are still needed, it is encouraging to note that more nurses are being employed each year while the assistance of various supporting classes is gradually dropping and that the hours of care per diem continue to increase.

TABLE A6**Comparison of Nursing Department Hours of Work for the Years 1965 and 1966**

(Includes hours of Nursing Education Staff but excludes Service and Educational hours of Students and Trainee Nursing Assistants)

Hospitals By Number of Beds	Hours of Care Per Diem ²			Hours of Graduate Nurses as a % of Total Hours		
	1965	1966	Increase (Decrease)	1965	1966	Increase (Decrease)
GENERAL HOSPITALS						
GROUP A						
900 +	6.5	6.7	.2	46.5	47.8	1.3
500-899	6.4	6.9	.5	56.1	56.1	—
200-499	6.3	6.9	.6	61.6	62.3	.7
Other Group A Hospitals ¹	8.5	7.9	(.6)	56.7	56.9	.2
Total Group A Hospitals	6.6	6.9	.3	52.9	53.6	.7
GROUPS B AND C						
400 +	5.9	6.2	.3	54.0	54.6	.6
350-399	6.1	6.3	.2	50.8	52.7	1.9
300-349	6.3	6.4	.1	56.2	56.9	.7
250-299	6.3	6.4	.1	53.6	54.5	.9
200-249	6.3	6.4	.1	54.6	56.9	2.3
150-199	6.1	6.3	.2	53.2	52.7	(.5)
100-149	6.2	6.3	.1	53.9	53.5	(.4)
Total Groups B and C—100 +	6.2	6.3	.1	54.0	54.7	.7
GROUPS B AND C						
50-99	5.9	6.0	.1	51.2	52.8	1.6
1-49	5.4	5.5	.1	53.4	54.3	.9
Total Groups B and C—1-99	5.7	5.9	.2	51.8	53.1	1.3
GROUP D						
5-22	5.7	5.8	.1	67.7	63.0	(4.7)
Total Groups A to D	6.3	6.5	.2	53.4	54.2	.8
CONVALESCENT HOSPITALS						
Group E	3.9	4.0	.1	36.6	41.5	4.9
HOSPITALS FOR THE CHRONICALLY ILL						
Groups F and G	4.0	4.2	.2	25.8	26.6	.8
Total Groups A to G	6.0	6.2	.2	51.2	52.2	1.0
PSYCHIATRIC HOSPITAL						
Group H ³	—	8.2	—	—	82.0	—
GRAND TOTAL—						
GROUPS A TO H	—	6.2	—	—	52.2	—

¹Other Group A Hospitals are the Hospital for Sick Children, the Princess Margaret and Sunnybrook Hospital.²Hours of care per diem were based on total adult and child days of care plus $\frac{1}{4}$ newborn days of care.³Group H, Clarke Institute of Psychiatry, Toronto, opened May 18, 1966.

Hours of Qualified Nursing Assistants as a % of Total Hours			Hours of Orderlies as a % of Total Hours			Hours of Other Nursing Department Personnel as a % of Total Hours		
1965	1966	Increase (Decrease)	1965	1966	Increase (Decrease)	1965	1966	Increase (Decrease)
16.8	14.9	(1.9)	10.8	10.4	(.4)	25.9	26.9	1.0
10.2	10.4	.2	9.2	8.4	(.8)	24.5	25.1	.6
12.4	12.1	(.3)	5.5	5.4	(.1)	20.5	20.2	(.3)
15.7	17.9	2.2	.9	6.7	5.8	26.7	18.5	(8.2)
13.5	13.0	(.5)	8.7	8.7	—	24.9	24.7	(.2)
12.8	14.0	1.2	6.9	6.6	(.3)	26.3	24.8	(1.5)
17.0	17.0	—	6.9	6.3	(.6)	25.3	24.0	(1.3)
22.2	20.3	(1.9)	4.6	4.6	—	17.0	18.2	1.2
15.5	16.6	1.1	4.7	4.3	(.4)	26.2	24.6	(1.6)
18.8	18.4	(.4)	5.6	5.4	(.2)	21.0	19.3	(1.7)
20.1	22.9	2.8	5.3	5.2	(.1)	21.4	19.2	(2.2)
25.2	24.8	(.4)	4.0	4.1	.1	16.9	17.6	.7
18.7	18.9	.2	5.4	5.2	(.2)	21.9	21.2	(.7)
26.0	23.7	(2.3)	4.4	4.7	.3	18.4	18.8	.4
22.1	23.0	.9	2.9	2.2	(.7)	21.6	20.5	(1.1)
25.0	23.6	(1.4)	4.0	4.1	.1	19.2	19.2	—
29.1	30.3	1.2	3.2	6.7	3.5	—	—	—
17.6	17.3	(.3)	6.4	6.4	—	22.6	22.1	(.5)
18.5	17.3	(1.2)	13.3	11.1	(2.2)	31.6	30.1	(1.5)
14.7	13.5	(1.2)	9.8	9.4	(.4)	49.7	50.5	.8
17.5	17.1	(.4)	6.8	6.7	(.1)	24.5	24.0	(.5)
—	7.2	—	—	—	—	—	10.8	—
—	17.1	—	—	6.7	—	—	24.0	—

TABLE A7

Comparison of Nursing Department Hours of Care Per Diem and Distribution of Graduate Nurse Hours of Work, 1965 and 1966

(Includes hours of Nursing Education Staff but excludes Service and Educational hours of Students and Trainee Nursing Assistants)

Hospitals By Number of Beds	Hours of Care Per Diem ²			Hours of Directors, Assoc. Directors and Asst. Directors as a % of Total Hours			Hours of Supervisors as a % of Total Hours		
	1965	1966	Increase (Decrease)	1965	1966	Increase (Decrease)	1965	1966	Increase (Decrease)
GENERAL HOSPITALS									
GROUP A									
900 +	6.5	6.7	.2	.6	.6	—	3.1	3.1	—
500-899	6.4	6.9	.5	.6	.6	—	2.6	2.5	(.1)
200-499	6.3	6.9	.6	1.4	1.4	—	2.9	2.8	(.1)
Other Group A Hospitals ¹	8.5	7.9	(.6)	1.2	.9	(.3)	3.6	3.6	—
Total Group A Hospitals	6.6	6.9	.3	.7	.7	—	2.9	2.9	—
GROUPS B AND C									
400 +	5.9	6.2	.3	1.0	.9	(.1)	2.7	2.7	—
350-399	6.1	6.3	.2	.8	.9	.1	4.3	4.1	(.2)
300-349	6.3	6.4	.1	.7	.6	(.1)	3.0	3.1	.1
250-299	6.3	6.4	.1	.9	.9	—	3.4	3.1	(.3)
200-249	6.3	6.4	.1	1.3	1.3	—	3.6	3.5	(.1)
150-199	6.1	6.3	.2	1.7	2.0	.3	4.3	4.1	(.2)
100-149	6.2	6.3	.1	1.3	1.3	—	5.5	5.1	(.4)
Total Groups B and C—100+	6.2	6.3	.1	1.1	1.0	(.1)	3.7	3.6	(.1)
GROUPS B AND C									
50-99	5.9	6.0	.1	1.9	1.8	(.1)	6.5	6.3	(.2)
1-49	5.4	5.5	.1	2.5	3.0	.5	6.1	5.1	(1.0)
Total Groups B and C—1-99	5.7	5.9	.2	2.1	2.1	—	6.4	6.0	(.4)
GROUP D									
5-22	5.7	5.8	.1	—	—	—	—	—	—
Total Groups A to D	6.3	6.5	.2	1.1	1.0	(.1)	3.7	3.6	(.1)
CONVALESCENT HOSPITALS									
Group E	3.9	4.0	.1	1.1	.9	(.2)	3.9	3.6	(.3)
HOSPITALS FOR THE CHRONICALLY ILL									
Groups F and G	4.0	4.2	.2	1.1	1.0	(.1)	2.9	2.7	(.2)
Total Groups A to G	6.0	6.2	.2	1.1	1.0	(.1)	3.6	3.5	(.1)
PSYCHIATRIC HOSPITALS									
Group H ³	—	8.2	—	—	2.1	—	—	1.8	—
GRAND TOTAL—GROUPS A TO H									
	—	6.2	—	—	1.0	—	—	3.5	—

¹Other Group A Hospitals are the Hospital for Sick Children, the Princess Margaret, and Sunnybrook Hospital.

²Hours of care per diem were based on total adult and child days of care plus $\frac{1}{4}$ newborn days of care.

³Group H, Clarke Institute of Psychiatry, Toronto, opened May 18, 1966.

Hours of Head Nurses, Asst. Head Nurses as a % of Total Hours			Hours of Instructors as a % of Total Hours			Hours of General Duty and Other Graduate Nurses as a % of Total Hours			Total Hours of Graduate Nurses as a % of Total Nursing Department Hours		
1965	1966	Increase (Decrease)	1965	1966	Increase (Decrease)	1965	1966	Increase (Decrease)	1965	1966	Increase (Decrease)
7.9	7.3	(.6)	2.5	2.3	(.2)	32.4	34.5	2.1	46.5	47.8	1.3
6.7	7.0	.3	2.9	3.0	.1	43.3	43.0	(.3)	56.1	56.1	—
9.3	9.0	(.3)	3.0	3.0	—	45.0	46.1	1.1	61.6	62.3	.7
8.0	9.7	1.7	2.7	3.0	.3	41.2	39.7	(1.5)	56.7	56.9	.2
7.6	7.6	—	2.7	2.7	—	39.0	39.7	.7	52.9	53.6	.7
7.5	7.0	(.5)	3.2	3.5	.3	39.6	40.5	.9	54.0	54.6	.6
6.5	6.5	—	2.6	2.8	.2	36.6	38.4	1.8	50.8	52.7	1.9
8.0	8.2	.2	1.5	1.6	.1	43.0	43.4	.4	56.2	56.9	.7
7.4	7.5	.1	2.3	2.6	.3	39.6	40.4	.8	53.6	54.5	.9
6.9	6.6	(.3)	2.9	3.1	.2	39.9	42.4	2.5	54.6	56.9	2.3
7.6	6.9	(.7)	3.2	3.7	.5	36.4	36.0	(.4)	53.2	52.7	(.5)
8.6	9.7	1.1	.7	.6	(.1)	37.8	36.8	(1.0)	53.9	53.5	(.4)
7.5	7.5	—	2.4	2.5	.1	39.3	40.1	.8	54.0	54.7	.7
7.6	7.6	—	.3	.3	—	34.9	36.8	1.9	51.2	52.8	1.6
6.5	6.9	.4	—	—	—	38.3	39.3	1.0	53.4	54.3	.9
7.3	7.4	.1	.2	.3	.1	35.8	37.3	1.6	51.8	53.1	1.3
8.6	11.9	3.3	—	—	—	59.1	51.1	(8.0)	67.7	63.0	(4.7)
7.5	7.6	.1	2.2	2.3	.1	38.9	39.7	.8	53.4	54.2	.8
4.4	4.7	.3	.1	.1	—	27.1	32.2	5.1	36.6	41.5	4.9
6.9	7.0	.1	.4	.4	—	14.5	15.5	1.0	25.8	26.6	.8
7.4	7.4	—	2.1	2.2	.1	37.0	38.1	1.1	51.2	52.2	1.0
—	8.3	—	—	8.5	—	—	61.3	—	—	82.0	—
—	7.4	—	—	2.2	—	—	38.1	—	—	52.2	—

TABLE A8
Comparison of Full-time Equivalent Nursing Department Personnel by
Classification for the Years 1965 and 1966

Hospitals By Number of Beds	Graduate Nurses			Qualified Nursing Assistants		
	F.T. Equiv. 1965	F.T. Equiv. 1966	Increase or (Decrease)	F.T. Equiv. 1965	F.T. Equiv. 1966	Increase or (Decrease)
GENERAL HOSPITALS						
GROUP A						
900 +	2,198.7	2,358.7	160.0	791.9	731.7	(60.2)
500-899	2,708.0	2,917.3	209.3	491.9	539.4	47.5
200-499	743.1	837.4	94.3	149.9	162.5	12.6
Other Group A Hospitals ¹	623.6	711.7	88.1	172.9	224.3	51.4
Total Group A Hospitals	6,273.4	6,825.1	551.7	1,606.7	1,657.8	51.1
GROUPS B AND C						
400 +	1,534.1	1,614.4	80.3	362.1	414.0	51.9
350-399	1,172.4	1,392.5	220.1	393.2	449.7	56.5
300-349	1,888.1	2,005.7	117.6	745.2	715.6	(29.6)
250-299	1,211.5	1,417.8	206.3	351.5	431.1	79.6
200-249	1,517.0	1,516.7	(.3)	521.7	490.7	(31.0)
150-199	1,053.4	976.2	(77.2)	399.3	424.2	24.9
100-149	1,126.5	1,232.5	106.0	525.6	572.4	46.9
Total Groups B and C—100 +	9,502.8	10,155.8	653.0	3,298.6	3,497.6	199.0
GROUPS B AND C						
50-99	1,420.0	1,562.6	142.6	721.1	702.0	(19.1)
1-49	521.9	490.3	(31.6)	215.8	208.0	(7.8)
Total Groups B and C—1-99	1,941.9	2,052.9	111.0	936.9	910.1	(26.8)
GROUP D						
5-22	69.8	69.1	(.7)	30.0	33.2	3.2
Total Groups A to D	17,787.9	19,102.9	1,315.0	5,872.3	6,098.7	226.4
CONVALESCENT HOSPITALS						
Group E	329.2	410.1	80.9	166.4	171.1	4.7
HOSPITALS FOR THE CHRONICALLY ILL						
Groups F and G	587.8	622.5	34.7	335.8	316.8	(19.0)
Total Groups A to G	18,704.9	20,135.5	1,430.6	6,374.5	6,586.6	212.1
PSYCHIATRIC HOSPITAL						
GROUP H ²	—	41.7	—	—	3.6	—
GRAND TOTAL A TO H	—	20,177.3	—	—	6,590.2	—

¹Other Group A Hospitals are the Hospital for Sick Children, the Princess Margaret and Sunnybrook Hospital.

²Group H, Clarke Institute of Psychiatry, Toronto, opened May 18, 1966.

Note: Totals have been calculated based on the actual paid hours of work and have been rounded to add across but not to add down.

F.T. Equiv. 1965	Orderlies F.T. Equiv. 1966	Increase or (Decrease)	Other Nursing Department Personnel			Total Nursing Department Personnel		
			F.T. Equiv. 1965	F.T. Equiv. 1966	Increase or (Decrease)	F.T. Equiv. 1965	F.T. Equiv. 1966	Increase or (Decrease)
511.7	512.9	1.2	1,223.2	1,326.8	103.6	4,725.5	4,930.1	204.6
441.5	439.6	(1.9)	1,184.2	1,307.2	123.0	4,825.6	5,203.5	377.9
65.9	72.5	6.6	247.2	271.7	24.5	1,206.1	1,344.1	138.0
9.7	84.2	74.5	294.4	230.6	(63.8)	1,100.6	1,250.8	150.2
1,028.8	1,109.2	80.4	2,949.0	3,136.4	187.4	11,857.9	12,728.5	870.6
195.4	194.7	(.7)	748.3	732.7	(15.6)	2,839.9	2,955.8	115.9
158.1	166.9	8.8	583.5	635.4	51.9	2,307.2	2,644.5	337.3
154.3	161.3	7.0	572.6	642.7	70.1	3,360.2	3,525.3	165.1
105.7	113.3	7.6	591.3	639.0	47.7	2,260.0	2,601.2	341.2
155.1	142.9	(12.2)	581.5	514.4	(67.1)	2,775.3	2,664.7	(110.6)
104.6	95.9	(8.7)	424.2	355.4	(68.8)	1,981.5	1,851.7	(129.9)
83.7	94.4	10.7	353.1	407.0	53.9	2,088.9	2,306.3	217.4
957.0	969.4	12.4	3,854.5	3,926.6	72.1	17,612.9	18,549.4	936.5
121.5	139.0	17.5	509.0	556.8	47.8	2,771.6	2,960.4	188.8
28.3	19.7	(8.6)	211.3	185.3	(26.0)	977.3	903.3	(74.0)
149.8	158.6	8.8	720.3	742.1	21.8	3,748.9	3,863.7	114.8
3.3	7.3	4.0	—	—	—	103.1	109.6	6.5
2,138.8	2,244.5	105.7	7,523.7	7,805.1	281.4	33,322.7	35,251.2	1,928.5
119.9	109.4	(10.5)	284.2	296.7	12.5	899.7	987.3	87.6
222.5	219.1	(3.4)	1,131.8	1,180.9	49.1	2,277.9	2,339.3	61.4
2,481.2	2,573.0	91.8	8,939.8	9,282.7	342.9	36,500.4	38,577.8	2,077.4
—	—	—	—	5.5	—	—	50.8	—
—	2,573.0	—	—	9,288.2	—	—	38,628.7	—

TABLE A9

**Comparison of Full-time Equivalent Nursing Department Personnel by
Classification for the Years 1965 and 1966**

Hospitals By Number of Beds	Directors, Associate Directors and Assistant Directors			Supervisors		
	F.T Equiv. 1965	F.T Equiv. 1966	Increase or (Decrease)	F.T Equiv. 1965	F.T Equiv. 1966	Increase or (Decrease)
GENERAL HOSPITALS						
GROUP A						
900 +	28.9	31.8	2.9	146.6	152.1	5.5
500-899	28.7	28.7	—	124.3	128.8	4.5
200-499	16.6	18.5	1.9	34.7	38.0	3.3
Other Group A Hospitals ¹	12.9	11.9	(1.0)	39.7	45.5	5.8
Total Group A Hospitals	87.1	90.9	3.8	345.3	364.4	19.1
GROUPS B AND C						
400 +	27.8	26.5	(1.3)	77.4	79.9	2.5
350-399	19.0	23.3	4.3	98.3	109.4	11.1
300-349	22.4	21.9	(.5)	99.4	107.6	8.2
250-299	20.4	22.5	2.1	76.6	81.1	4.5
200-249	36.2	33.6	(2.6)	99.9	93.9	(6.0)
150-199	33.9	36.4	2.5	84.7	76.1	(8.6)
100-149	28.1	29.2	1.1	115.4	118.5	3.1
Total Groups B and C—100 +	187.7	193.5	5.8	651.7	666.5	14.8
GROUPS B AND C						
50-99	54.0	53.0	(1.0)	179.3	185.8	6.5
1-49	24.2	26.6	2.4	60.0	46.3	(13.7)
Total Groups B and C—1-99	78.2	79.6	1.4	239.3	232.1	(7.2)
GROUP D						
5-22	—	—	—	—	—	—
Total Groups A to D	353.1	364.0	10.9	1,236.2	1,263.0	26.8
CONVALESCENT HOSPITALS						
Group E	10.0	9.2	(.8)	35.0	35.1	.1
HOSPITALS FOR THE CHRONICALLY ILL						
Groups F and G	24.1	24.5	.4	66.6	63.2	(3.4)
Total Groups A to G	387.2	397.7	10.5	1,337.9	1,361.2	23.3
PSYCHIATRIC HOSPITAL						
Group H ²	—	1.1	—	—	.9	—
GRAND TOTAL—GROUPS A TO H	—	398.8	—	—	1,362.1	—

¹Other Group A Hospitals are the Hospital for Sick Children, the Princess Margaret Hospital and Sunnybrook Hospital.

²Group H, Clarke Institute of Psychiatry, Toronto, opened May 18, 1966.

Totals have been calculated based on the actual paid hours of work and have been rounded to add across not to add down.

Head Nurses and Assistant Head Nurses			Instructors			General Duty and Other Graduate Nurses			TOTAL GRADUATE NURSES		
F.T. Equiv. 1965	F.T. Equiv. 1966	Increase or (Decrease)	F.T. Equiv. 1965	F.T. Equiv. 1966	Increase or (Decrease)	F.T. Equiv. 1965	F.T. Equiv. 1966	Increase or (Decrease)	F.T. Equiv. 1965	F.T. Equiv. 1966	Increase or (Decrease)
373.4	361.9	(11.5)	116.3	115.7	(.6)	1,533.5	1,697.2	163.7	2,198.7	2,358.7	160.0
323.7	367.3	43.6	138.3	153.5	15.2	2,093.0	2,239.0	146.0	2,708.0	2,917.3	209.3
112.5	121.2	8.7	35.8	39.7	3.9	543.5	620.0	76.5	743.1	837.4	94.3
87.8	120.7	32.9	29.4	37.7	8.3	453.8	495.9	42.1	623.6	711.7	88.1
897.3	971.1	73.8	319.8	346.6	26.8	4,623.9	5,052.1	428.2	6,273.4	6,825.1	551.7
211.6	206.6	(5.0)	91.9	104.4	12.5	1,125.4	1,197.0	71.6	1,534.1	1,614.4	80.3
150.9	172.2	21.3	59.6	72.4	12.8	844.6	1,015.2	170.6	1,172.4	1,392.5	220.1
269.1	290.1	21.0	52.0	56.4	4.4	1,445.2	1,529.7	84.5	1,888.1	2,005.7	117.6
167.0	195.3	28.3	52.1	67.9	15.8	895.4	1,051.0	155.6	1,211.5	1,417.8	206.3
192.8	177.0	(15.8)	79.7	82.1	2.4	1,108.4	1,130.1	21.7	1,517.0	1,516.7	(.3)
150.1	128.5	(21.6)	64.3	69.0	4.7	720.4	666.2	(54.2)	1,053.4	976.2	(77.2)
179.9	223.4	43.5	13.7	13.4	(.3)	789.4	848.0	58.6	1,126.5	1,232.5	106.0
321.3	1,393.1	71.8	413.4	465.6	52.2	6,928.7	7,437.1	508.4	9,502.8	10,155.8	653.0
209.3	223.7	14.4	8.3	10.5	2.2	969.1	1,089.6	120.5	1,420.0	1,562.6	142.6
64.0	62.2	(1.8)	—	—	—	373.7	355.2	(18.5)	521.9	490.3	(31.6)
273.3	285.9	12.6	8.3	10.5	2.2	1,342.8	1,444.8	102.0	1,941.9	2,052.9	111.0
8.9	13.0	4.1	—	—	—	60.9	56.1	(4.8)	69.8	69.1	(.7)
2,500.8	2,663.1	162.3	741.5	822.7	81.2	12,956.3	13,990.1	1,033.8	17,787.9	19,102.9	1,315.0
39.8	46.8	7.0	1.0	1.0	—	243.4	318.0	74.6	329.2	410.1	80.9
157.1	162.6	5.5	9.3	8.8	(.5)	330.7	363.4	32.7	587.8	622.5	34.7
2,697.6	2,872.6	175.0	751.8	832.5	80.7	13,530.4	14,671.5	1,141.1	18,704.9	20,135.5	1,430.6
—	4.2	—	—	4.3	—	—	31.2	—	—	41.7	—
—	2,876.8	—	—	836.9	—	—	14,702.7	—	—	20,177.3	—

TABLE A10

**Full-time Equivalent Staff by Classification for Years 1964 to 1966 and
Projected for Years 1967 and 1968**

Also Percentage Increases or Decreases for Years 1965/1964 and 1966/1965

Public, Active, Chronic, Convalescent and Psychiatric Hospitals

Based on 1964, 1965 and 1966 Annual Return of Hospitals Form HS-1

Classification of Nursing Department Staff	1964 Full-time Equivalent	% of Total	1965 Full-time Equivalent	% of Total	% Increase or (Decrease) 1965/1964
Directors, Associate Directors and Assistant Directors of Nursing Services and Nursing Education	376.1	1.1	387.2	1.1	3.0
Nursing Supervisors	1,311.2	3.7	1,337.9	3.6	2.0
Head Nurses	1,625.2	4.7	1,723.7	4.7	6.1
Assistant Head Nurses	936.7	2.7	973.9	2.7	4.0
Instructors	696.4	2.0	751.8	2.1	8.0
Graduate Nurses—General Duty (Nursing Units)	10,136.0	29.1	10,816.9	29.6	6.7
Graduate Nurses — Other (Special Nursing Services—Plaster Room, Dressing Room, O.R., Emergency Unit, Delivery Room, O.P.D., etc.)	2,454.5	7.0	2,713.5	7.4	10.6
TOTAL GRADUATE NURSES	17,536.1	50.3	18,704.9	51.2	6.7
Qualified Nursing Assistants	6,028.8	17.3	6,374.5	17.5	5.7
Orderlies	2,454.4	7.0	2,481.2	6.8	1.1
Other Nursing Department Personnel	8,845.6	25.4	8,939.8	24.5	1.1
GRAND TOTAL	34,864.9	100.0	36,500.4	100.0	4.7
% Increase 1965/1964			4.7		
% Increase 1966/1965					
Projected % Increase 1967/1966					
Projected % Increase 1968/1967					

Full-time Equivalent	1966 % of Total	% Increase or (Decrease) 1966/1965	1967 Projected % of Total	Projected Full-time Equivalent	1968 Projected % of Total	Projected Full-time Equivalent
398.8	1.0	3.0	1.1	460.9	1.1	495.8
1,362.1	3.5	1.8	3.6	1,508.4	3.6	1,622.7
1,791.6	4.6	3.9	4.7	1,969.2	4.7	2,118.6
1,085.2	2.8	11.4	2.7	1,131.3	2.7	1,217.0
836.9	2.2	11.3	2.2	921.8	2.2	991.7
11,751.5	30.4	8.6	31.2	13,072.4	32.0	14,424.2
2,951.2	7.7	8.8	8.0	3,351.9	8.3	3,741.3
20,177.3	52.2	7.9	53.5	22,415.9	54.6	24,611.3
6,590.2	17.1	3.4	17.0	7,122.8	17.0	7,662.8
2,573.0	6.7	3.7	6.7	2,807.2	6.7	3,020.1
9,288.2	24.0	3.9	22.8	9,553.0	21.7	9,781.4
38,628.7	100.0	5.8	100.0	41,898.9	100.0	45,075.6
5.8				8.5		7.6

Appendix III

Copy of a study of nursing supply and demand from 1960-1970 prepared for the "Nursing Education Advisory Committee Advisory to the Minister of Health"

Future Needs for Registered Nurses

As requested, I have prepared a set of estimates predicting the number of registered nurses which will be needed between 1965 and 1970, and the surplus or deficit that might be created because of the nursing facilities now in existence and planned for development during this period.

It should be noted that these estimates, as far as nurses employed in hospitals and other related health institutions and facilities are concerned, have been based on governmental records. Thus, the latest projections differ quite radically from those previously based on RNAO data, and cannot be compared with them. It is believed, however, that despite certain limitations associated with governmental records, they do provide a more accurate assessment of the true situation, since the number of nurses reporting employment status at the time of their annual registration with the RNAO is now less than half the number who become registered.

While details of how the various calculations were made are not outlined herein, the significant assumptions that form the bases for these estimates and the major factors that influence them are listed below for your information:

- 1) Actual figures were collected and studied for the years 1960-1965 inclusive. Most of the averages or percentages used for projection purposes were based on actual experience within this time interval.
- 2) Projections beyond 1970 were not considered practical for the following reasons:
 - a) construction plans for several proposed medical teaching facilities are still indefinite;
 - b) the mental health program in the province is still undergoing considerable change; and
 - c) major alterations to the present nursing education program will not likely occur to any appreciable degree before 1970.
- 3) For bed projection purposes, it was assumed that the university teaching hospitals currently proposed would be completed and ready for operation sometime between 1967 and 1969, although it is quite possible not all would be ready this early. Also it was

TABLE 1

Estimated Registered Nursing Needs for 1965-1970
Based on Actual Data for 1960-1965 and Using a Ratio of .43
Registered Nurses per "Public and Private" Hospital Bed¹

YEAR	Population of Ontario (in 000's)	Hospital Beds ²	NUMBER OF FULL AND PART-TIME REGISTERED NURSES		
			Employed in Nursing	In Non-Nursing Activities	TOTAL
1960	6,111.0	61,323	24,691	10,128	34,819
1961	6,236.0	64,218	25,641	12,367	38,008
1962	6,342.0	62,536	28,347	12,689	41,036
1963	6,448.0	63,270	31,167	12,824	43,991
1964	6,586.0	64,360	30,687	16,050	46,737
1965	6,731.0	60,923	32,789	15,078	47,867
1966	6,832.0	62,592	33,780	15,534	49,314
1967	6,965.0	65,640	35,661	16,399	52,060
1968	7,103.0	68,601	37,537	17,261	54,798
1969	7,246.0	70,796	38,878	17,878	56,756
1970	7,394.0	71,528	39,201	18,027	57,228

¹Actual figures used for 1960-1964. Figures for 1965-1970 estimated on basis of .43 registered nurses utilized per bed in public, private (including temporarily approved nursing homes) and federal hospitals combined, .044 registered nurses per long-term mental bed, and .07 registered nurses per bed utilized for tuberculosis patients. These were the standards in effect in 1964.

²Actual and projected beds in public, private and federal hospitals, temporarily approved nursing homes, public and private mental institutions and tuberculosis sanatoria.

assumed there would be another significant transfer in 1965 of mental patients to residential units within existing provincial mental institutions. Beds in residential units are not included in the bed estimates for the long-term mentally ill. Bed projections for public, private, and federal hospitals, including temporarily approved nursing homes, allow for 7.5 beds per 1,000 population by 1969, decreasing to 7.4 in 1970. Similarly, the allowance for long-term mental beds was made on the basis of 2.1 beds per 1,000 popula-

TABLE 2

Estimated Registered Nursing Needs for 1965-1970 Based on .5 Registered Nurses per "Public and Private" Hospital Bed^{1, 2}

YEAR	NUMBER OF FULL AND PART-TIME REGISTERED NURSES ²		
	Employed in Nursing	In Non-Nursing Activities	Total
1965	37,944	17,449	55,393
1966	39,093	17,977	57,070
1967	41,278	18,982	60,260
1968	43,457	19,984	63,441
1969	45,013	20,699	65,712
1970	45,387	20,871	66,258

¹"Public and Private" beds includes beds in public, private and federal hospitals, including temporarily approved nursing homes.

²Nursing figures estimated on basis of .5 registered nurses per "public and private" beds, .044 registered nurses per long-term mental bed, and .07 registered nurses per bed utilized for tuberculous patients.

TABLE 3

Estimated Surplus or Shortage of Registered Nurses

1965 - 1970

YEAR	Potential Number of Registered Nurses	Expected New Graduates in Nursing	REGISTERED NURSING NEEDS		SURPLUS (+) or DEFICIT (—)	
			Based on Table 1	Based on Table 2	Based on Table 1	Based on Table 2
1965	49,721	3,320	47,867	55,393	+ 1,854	— 5,672
1966	53,041	3,656	49,314	57,070	+ 3,727	— 4,029
1967	56,697	3,992	52,060	60,260	+ 4,637	— 3,563
1968	60,689	4,328	54,798	63,441	+ 5,891	— 2,752
1969	65,017	4,664	56,756	65,712	+ 8,261	— 695
1970	69,681	5,000	57,228	66,258	+ 12,453	+ 3,423

tion. Beds for tuberculosis care were reduced at the rate of 9.1 per cent per annum, the average decline noted between 1960 and 1964.

- 4) Statistics concerning full and part-time registered nurses include instructors in hospitals, but exclude students.
- 5) Since the start of the plan all hospitals (except long-term mental) and tuberculosis sanatoria report the number of *graduate* nurses on staff. A graduate nurse is defined to be a person who has graduated from a school of nursing approved by the legally-appointed body in the province and *qualified to take* examination for registered nurse. In the two years prior to the plan, hospitals reported statistics on graduate nurses and registered nurses, both on a full-time and part-time basis. Statistics for these two years (1957 and 1958) showed that:
 89.2 per cent of all graduate nurses in public general hospitals were registered.
 71.0 per cent of all graduate nurses in public convalescent and chronic hospitals were registered.
 Between 1960 and 1964, an average of 75.0 per cent of all graduate nurses working in long-term mental hospitals were registered. This latter percentage was also assumed to apply in tuberculosis units of sanatoria.
- 6) Between 1960 and 1964 the ratio of registered nurses to "public and private" beds improved from .383 to .430. The ratio of registered nurses in long-term mental institutions rose in this same period from .032 to .044; the improvement being largely attributable to the movement of over 3,600 patients to residential units. The ratio of registered nurses to beds for tuberculosis patients remained constant at .07. The 1964, or most favourable, ratios (.430, .044 and .07) were used in Table 1 to project registered nursing needs in hospitals and related institutions for the years 1965 to 1970. In Table 2 the estimates reflect the needs when the .43 ratio is raised to .5 and the other two ratios are held constant.
- 7) Registered nurses employed in hospital or comparable work were assumed to account for 62.2 per cent of all registered nurses employed in nursing occupations. Thus 37.8 per cent of all registered nurses employed in nursing were assumed to be occupied in such work as public or occupational health, private or office nursing, etc.
- 8) Between 1960 and 1964, the total number of registered nurses employed in nursing occupations accounted for 68.5 per cent of

Worksheet No. 1 — Estimate of Registered Nursing Needs

Year	Population of Ontario (in 000's)	BED PROJECTIONS			Public, private, federal and temporarily approved nursing homes	Long-term mental, excl. federal	Tuberculosis
		Public, private, federal and t.a. nursing homes	Long-term mental incl. federal	Tuberculosis			
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1960	6111.0	37,835	20,864	2,624	14,493	666	199
1961	6236.0	39,371	23,364	2,483	15,107	674	168
1962	6342.0	41,097	19,061	2,378	16,428	698	166
1963	6448.0	43,133	18,129	2,008	17,783	777	140
1964	6586.0	44,594	18,331	1,435	19,195	805	100
1965	6731.0	45,795	13,823	1,305	@ .43 19,692 @ .5 22,898	608	95
1966	6832.0	47,218	14,187	1,187	20,304 23,609	624	83
1967	6965.0	49,908	14,652	1,080	21,460 24,954	645	76
1968	7103.0	52,601	15,018	982	22,618 26,300	661	69
1969	7246.0	54,518	15,385	893	23,443 27,259	677	62
1970	7394.0	54,961	15,755	812	23,633 27,481	693	57
1971	7527.0	55,461	16,183	739	23,848 27,730	712	52
1972	7702.0	56,386	16,559	672	24,246 28,193	729	47
1973	7877.0	57,259	16,935	611	24,621 28,630	745	43
1974	8052.0	58,186	17,312	556	25,020 29,093	762	39
1975	8227.0	59,295	17,688	506	25,497 29,648	778	35

Worksheet No. 2 — Surplus or Deficit Based on Projected Supply of Registered Nurses

Year	Actual and projected R.N. labour force in Ontario	Nurse graduates of general hospitals	Nurse graduates from specialty hospitals, universities, independent schools	Total nurse graduates	% of hospital grads. to total grads. (col. 2 ÷ col. 4)
(1)	(2)	(3)	(4)	(5)	(6)
ACTUAL	1959	33,409			
	1960	34,819	1,881	2,005	93.8
	1961	38,008	1,910	2,063	92.6
	1962	41,036	2,096	2,293	91.4
	1963	43,991	2,174	2,410	90.2
	1964	46,737	2,353	2,648	88.9
ESTIMATED	1965	49,721		2,984	
	1966	53,041		3,320	
		(50,721)			
	1967	56,697		3,656	
	1968	60,689		3,992	
	1969	65,017		4,328	
	1970	69,681		4,664	
				5,000	

REGISTERED NURSES FULL AND PART-TIME									
Total required in inst. work incl. instructors but excl. students		Other Nursing Occupations		Total Registered Nurses required in nursing occupations		Total Registered Nurses employed in other activities		Total Registered Nurses required	
(9)		(10)		(11)		(12)		(13)	
15,358		9,333		24,691		10,128		34,819	
15,949		9,692		25,641		12,367		38,008	
17,292		11,055		28,347		12,689		41,036	
18,700		12,467		31,169		12,824		43,991	
20,100		10,587		30,687		16,050		46,737	
@ .43	@ .5	@ .43	@ .5	@ .43	@ .5	@ .43	@ .5	@ .43	@ .5
20,395	23,601	12,394	14,343	32,789	37,944	15,078	17,449	47,869	55,393
21,011	24,316	12,769	14,777	33,780	39,093	15,534	17,977	49,314	57,070
22,181	25,675	13,480	15,603	35,661	41,278	16,399	18,982	52,060	60,260
23,343	27,030	14,189	16,427	37,537	43,457	17,261	19,984	54,798	63,441
24,182	27,998	14,696	17,015	38,878	45,013	17,878	20,699	56,756	65,712
24,383	28,231	14,818	17,156	39,201	45,387	18,027	20,871	57,228	66,258
24,612	28,494	14,957	17,316	39,569	45,810	18,196	21,066	57,765	66,876
25,022	28,969	15,206	17,605	40,228	46,574	18,499	21,417	58,727	67,991
25,409	29,418	15,441	17,878	40,850	47,296	18,785	21,749	59,635	69,045
25,821	29,894	15,692	18,167	41,513	48,061	19,090	22,101	60,603	70,162
26,310	30,461	15,989	18,511	42,299	48,972	19,451	22,520	61,750	71,492

Projected theoretical registration for year shown	Net emigration (—) or immigration (+)	Total R.N.'s Required		Surplus or deficit	
(7)	(8)	@ .43	@ .5	@ .43	@ .5
		(9)		(10)	
35,414	—595				
36,882	+1,126				
40,301	+735				
43,446	+545				
46,639	+98				
49,721	—	47,867	55,395	+1,854	—5,672
53,041	—	49,314	57,070	+3,727	—4,029
56,697	—	52,060	60,260	+4,637	—3,563
60,689	—	54,798	63,441	+5,891	—2,752
65,017	—	56,756	65,712	+8,261	—695
69,631	—	57,228	66,258	+12,453	+3,423

all nurses who obtained registration. It was assumed this relationship would extend through to 1970. Thus in Tables 1 and 2, the figures shown for registered nurses from 1965 on reflect need based on a) existing standards in hospitals and related institutions in 1964, and b) on a slightly improved availability of nurses.

- 9) The potential number of registered nurses was obtained by increasing the actual number of registered nurses by the expected number of graduates each year (column 2 of Table 3). The number of graduates each year was raised in accordance with the overall objectives of the Minister of Health.
- 10) An inherent assumption in the estimation technique used to estimate the potential or available number of registered nurses is that the "net emigration" of registered nurses will offset "net immigration". "Net emigration" is defined to be any factor that contributes to lowering the availability of registered nurses in the province. Thus it would include such factors as death or retirement, emigration to other provinces or countries, graduates who do not write registration examinations and/or do not enter the nursing field, nurses on temporary leave of absence to take further educational training, etc. "Net immigration" includes nurses who come to Ontario, obtain provincial registration and enter the nursing labour force. Thus, if net emigration and net immigration do not offset one another and/or the desired increase in graduates is not achieved, the surplus in registered nurses shown in column 6 of Table 3 would be quickly reduced.
- 11) Another inherent assumption in the projections is that student nurses will continue to provide as much service between 1965 and 1970 as they have in the past.

The projections also indicate that if hospital construction falls off sharply for a number of years after the proposed university hospitals open, in order to bring the available beds closer to existing Commission planning standards, there could be too many training schools for the number of nurses required. The extent of the closure among existing schools at that time would, of course, depend on the extent to which the above assumptions prevailed in the interim and whether or not any change was anticipated in the length of the work week.

(Signed)
(Miss) Naomi I. Grigg,
Director, Statistical Research.

BINDING SECT. JAN 12 1971

